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THE JOURNAL OF CUTANEOUS DISEASES

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Original Communications

THE SO-CALLED POROKERATOSIS (MIBELLI) WITH SPECIAL REFERENCE TO ITS HISTOPATHOLOGY *

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Some of the keratotic diseases attack with predilection the hair follicles while others occur chiefly at the sites of the mouths of sweat-ducts. Mibelli considered his "porokeratosis" as a keratosis belonging to the latter category. He described the affection in 1893, and, basing his study on several cases and on consideration of the literature, he concluded that the disease was a new type of keratosis.

According to this writer, the disease exhibits, histologically as well as clinically, an entirely characteristic keratotic condition occurring at the sites of the orifices of sweat-ducts.

Respighi, who reported the same dermatosis, regarded it also as a hitherto undescribed affection, characterized by centrifugal extension of the keratotic patches.

Since that time a number of communications have appeared dealing with the subject: Joseph, Reisner, Heller, Harttung, Kullack, Baum, Basch, Brocq and Pautrier, Galloway, Hutchins, Gilchrist, Wende, Himmel, Mibelli, Respighi, Ducrey and Respighi, Lombardo, Scaduto, Pasini, Giani, etc., have reported cases. More than half of these were published by Italian dermatologists. In Japan, cases have been reported by Dohi and Ohno, Ito, Sei, Sakurane, Hirooka, Sekiba, Maki, Umezu, etc.

In regard to the histologic examination about thirty cases have been recorded; among these are those of Mibelli, Respighi, Ducrey and Respighi, Reisner, Joseph, Gilchrist, Wende, Basch, Kullack, Truffi, Himmel, Brocq and Pautrier, Scaduto, Dohi and Ohno, Ito, Sei, Maki, etc. Though some of the writers did not submit the histologic details and the others did not examine the microscopic specimens very care-

* Received for publication Feb. 12, 1918.
* From the clinic of Dr. Matsuura.

fully, the great majority of them (excepting Respighi, Gilchrist and others) were inclined to support Mibelli's view.

That the keratotic change in the disease is exclusively connected with the sweat structures is very doubtful. In fact, in the porokeratotic patches there are to be seen, not infrequently, minute horny plugs marking the sites of the follicles, and Respighi, Gilchrist, etc., noticed also evidences of follicular hyperkeratosis. It is rather strange that Mibelli neglected a careful examination of the follicular structures and did not discuss them more in detail. Obviously there is a great deficiency in our knowledge of the histopathology of the disease. Careful histologic investigations of the primary lesions are therefore particularly desirable to gain a better insight into the nature of the condition.

REPORT OF CASES

Although porokeratosis is a comparatively rare disease, we have had the good fortune to observe thirteen cases all of which were examined histologically.

The clinical findings of these cases are herewith briefly tabulated.

TABLE 1.—SUMMARY OF CLINICAL FINDINGS IN ELEVEN CASES OF POROKERATOSIS

Case No.	Age and Sex	Localization of the Eruption and Other Remarks
1*	19 years Male	Duration of the disease nearly from 12 to 13 years, first appearing on the sole of the foot. Refer to Fig. 1, a, b, and Fig. 3, a, b, where the chief localization of the lesions are illustrated. In addition to these, several were seen on the face (right side) and interscapular region (right). Chiefly "porokeratosis systematisatus"
2	28 years Male	Existed nearly 25 years. Rapid progress since 10 years. Note Fig. 2, a, b, and Fig. 4. Several on lower extremity (right). Partly systematic arrangement
3	23 years Male	Appeared soon after birth. Systematic arrangement on costal region; further on cheek, forehead, eyelid, nose, neck, costal, gluteal and anal region
4	40 years Female	Since 2 years. Disseminated all over the cutaneous surface there are numerous lesions. Palms and soles free
7	21 years Male	Existed for years. About 10 efflorescences, aggregated, on the inner surface of right thigh
8	20 years Male	Since from 3 to 4 years. Interscapular region
9	40 years Male	Dorsum of the foot (right)
10	29 years Male	More than 20 years. Disseminated on face, chest, back and extremities. Heredity existed
11†	46 years Male	Duration 20 years. A typical plaque on the forehead. Both follicular (comedolike) and poral (scarcely visible) keratoses were most beautifully demonstrated in this case
12	22 years Male	Duration more than 3 years. Scattered on forehead, eyelid, flexure of the elbow (left), arm (right), abdomen and legs. At times moderate itching. Spontaneous healing was seen at places
13	26 years Male	Since 7 years. Scattered on face, scalp, axillae, back and legs, a dozen in toto. The eruption exhibited marked inflammatory (chronic) change, brownish-red, sharply marginated, bearing certain resemblance to eczema marginatum. Larger plaques showed seborrheic scaliness. At places relative central healing. There was itching

* Cases 1 to 10: Refer to No. 35 in literature.
† Case 11: Refer to No. 36 in literature.

The diagnosis of the disease is not difficult save in its very early stage of development. It is not my present purpose to describe the clinical features in detail; therefore, I will confine myself to pointing out a few interesting features observed in my cases.

ETIOLOGY

Regarding the etiology and nature of the disease there exist various opinions and hypotheses (Tommasoli, Majocchi, Mibelli, Respighi, Wende, Gilchrist, etc.). Cases are on record, in which many members of a family have suffered from the disease (Respighi, Ducrey, Gilchrist, Mibelli, Lombardo, Pasini, etc.); the last named physician met with twenty-six cases in a family. Not all cases, however, give a hereditary history. The disease is more common in males than in females. The eruption may begin in childhood but not infrequently develops in adults of middle or advanced life.

The eruption does not usually exhibit an inflammatory change of the skin, but occasionally there is a marked reddening, suggesting that it is of a chronic inflammatory nature. Case 13 is an example of this. The eruption showed marked inflammatory reddening in association with itching and scaliness.

Subjective symptoms are usually absent; but, in Cases 12 and 13, there was itching. The horny growth of Case 1 situated on the sole (Fig. 3, a; literature No. 35 or 37), was so painful on pressure, that it gave rise to great discomfort.

Truffi, Baum, etc., described cases in which a systematic distribution of the eruption was observed (porokeratosis systematisatus). Examples of this are exceedingly rare. Cases 1, 2 and 3 may be classified under this category. Particularly, the localization of the patches on the upper and lower extremities of Case 1 is most interesting (compare literature No. 34).

That the lesion bears a certain resemblance to linear dermatoses or to lichen, in various ways (distribution of the patches, histologic features, heredity, etc.) is of interest in connection with this dermatosis.

HISTOLOGY

The histologic research was intended particularly to study the primary efflorescences with special reference to their relation to the skin glands, and further the "horny plugs" observed on the porokeratotic plaques. Needless to say that for the present purpose examinations in serial sections were necessary.

(1) PRIMARY EFFLORESCENCES.—The histologic investigation of the primary lesion has been hitherto rather neglected. There have appeared only several communications dealing with the subject, namely, those of Respighi, Mibelli, Ducrey and Respighi, Gilchrist, Himmel, etc. To my knowledge, an exact definition of the primary efflorescence

of porokeratosis does not exist. By the designation "primary efflorescence," is meant here, minute eruptions which are less than from 1 to 2 mm. in diameter, with or without a typical "wall." According to the clinical features, they may be classified as follows:

1. Very young ones, brownish, with or without a trace of roughness; no formation of wall (Refer to Table 2. Case 1, Nos. 1—5, 8—10).

2. Those with a trace of hyperkeratosis and a wall (Case 1, Nos. 7, 11, 12; Case 2, 1—5,; Case 4, 1, 2, 5, 6; Case 5).

3. Those with a typical wall on the peripheral border (Case 7, No. 3).

4. The efflorescence itself is either a horny plug or horny depression (Case 7, Nos. 1, 3).

5. Minute patches showing a horny plug on them (Case 6; Case 7, No. 2, etc.).

For the sake of brevity, the histologic findings obtained from the examination of more than thirty primary efflorescences will be summarized:

(*a*) The hyperkeratosis occurring in a primary efflorescence is so slight that it is, at times, not recognizable at all. Similarly, the acanthosis is slight. There is, usually, no morphologic change of the epithelial cells, but occasionally a slight edema exists in the rete in association with the infiltration in the papillary layer.

(*b*) One of the most remarkable features is the minute parakeratotic thickening of the epithelium (which takes the eosin stain well) at the peripheral border of the efflorescence. This corresponds to the horny ridge or wall surrounding the plaque, continuously or discontinuously. Such a wall may be partly or entirely absent in the youngest stage of the lesion.

(*c*) The mouths of the sweat-ducts and of the follicles are implicated in the hyperkeratotic process. Both may be affected nearly to a same extent or either of these may be predominantly altered. The follicle may occupy the center of the lesion. Where the sweat-pores are keratotic and thickened, the follicular openings, if they exist, are, as a rule, likewise changed. The parakeratotic thickened wall surrounding the plaque may occur at the sites of sweat-ducts, causing dilatation of their mouths. The sweat glands show morphologically no abnormality.

If hair-follicles are implicated in the process, it results occasionally in their dilatation. The comedolike horny plug or prominence existing in the efflorescence is nothing but an overgrowth of the horny layer at the mouth of the follicle.

(*d*) In the underlying papillary layers, there is more or less marked cell infiltration which is at times very remarkable, particularly along the peripheral border and around the follicles. The blood vessels may

occasionally be dilated. A highly characteristic feature, commonly associated with the infiltration, is the presence of pigment.

Occasionally, there occurs a disappearance of the elastic fibers in the papillary layer and particularly in the infiltration.

(*e*) The hyperkeratosis at the mouths of the sweat-ducts was not pronounced in my cases. There was no finding which leads us to believe that the disease commences with a keratotic eruption occupying the sites of the sweat-ducts. However, cases were observed in which the cornified hair-follicle occupied the center of the efflorescence.

Whether the change in the epithelium or in the cutis is primary, is a question still open for discussion. That there frequently exists marked infiltration in the papillary layer in spite of very slight hyperkeratosis, is in favor of the view that the disease has its origin in the cutis.

(2) RELATIVELY OLD PATCHES.—For the sake of convenience, the histologic findings in the center and the peripheral border of the porokeratotic plaque will be separately described. The changes of the sweat-glands and follicles as well as their relation to the horny plugs existing in the keratotic area were carefully investigated.

(*a*) *The Center.*—The smaller patches exhibit changes similar to those seen in primary efflorescences. The plaque, increasing slowly in size by peripheral extension, is surrounded by a sharply defined elevated border (so-called "wall"). The patches show at times marked hyperkeratosis with acanthosis, though this is not pronounced in the vast majority of our cases.

In the papillary layer and around the keratotic follicles there is, as a rule, more or less marked round-cell infiltration with occasionally dilated capillaries. The infiltration consists chiefly of mononuclear round cells mixed with plasma and mast cells. In exceptional instances, a certain number of giant cells can be found. The infiltration is at times very pronounced, bearing a certain resemblance to a lymph follicle (Case 4, No. 3; Case 7, No. 2). In addition, an increase in the number of wandering cells in the rete is occasionally associated.

In the relatively early stage, the elastic fibers do not usually show any pronounced change save in the infiltration, where they are not tingeable. In occasional cases the finer nets of elastic fibers in the papillary layer are not well demonstrable. In the old plaques of Case 11, removed from the forehead, there was observed so-called colloid degeneration occurring in the subpapillary layer which may not be due to the porokeratotic change (Refer to No. 36 in literature).

The central area of an old plaque exhibits, not infrequently, signs of atrophy. There is a diminution in the thickness of the epithelium (Fig. 13). An atrophy and flattening of the papilla takes place.

TABLE 2.—HISTOLOGIC CHARACTERISTICS OBSERVED IN A SERIES OF CASES OF POROKERATOSIS

Case No.	Pieces		Changes in Epidermis and Corium							Remarks
	Removed From	No.	Hyperkeratosis	Acanthosis	Formation of Wall	Follicular Keratosis	Poral Keratosis	Cell Infiltration	Deposition of Pigment	
1	Pectoral region	1	—(±)	—	—	±	—	+	++	
	Pectoral region	2	+	—	—	+	+	++	++	
	Pectoral region	3	+	—*	—	+	+	+	+	*Certain number of wandering cells present
	Pectoral region	4	+	±	—	..	+	+	+	
	Pectoral region	5	+	—	—	+	+	+	+	
	Pectoral region	6	++	—	+	++	+	+	++	
	Pectoral region	7	+	—	+	++	+	+	++	Fig. 6
	Pectoral region	8	—	—	—	—	—	+	++	Fig. 5
	Pectoral region	9	—	—	—	—	—	+	++	
	Pectoral region	10	—	—	—	—	—	+	++	
	Arm	11	+	±	+	+	+	+	++	
	Arm	12	+	—	+	..	—	++	++	
	Arm	13	..	—	+	+++	+	++	+	
	Arm	14	..	—	—	—	—	++	++	
2	Forearm	1	+	—†	+	±	±	+++	+	†Wandering cells
	Forearm	2	+	..	—	±	..	+++	+	
	Flexure of elbow	3	+	—	+	..	±	+	+	
	Forearm	4	+	—	+	..	±	+	+	
	Forearm	5	±	—	±	++	+	+	+	
3	.....	....	+	+	+	+++	+	+	++	
4	Back	1	+	—	±	—	—	+	+	
	Back	2	+	—	+	++	—±	++	++	
	Back	3	+	—‡	+	++	±	+++	+++	‡Edema and wandering cells Fig. 7
	Back	4	++	—	+	+	+	++	++	
	Back	5	+	±	±	—	±	++	++	
	Back	6	+	±	+±	±	±	++	++	
	Back	7	+	—	+	++	±	++	++	
	Back	8	+	—	+	..	+	++	++	
	Back	9	+	—	+	..	+	++	++	
5	.....	....	..	—	±	+++	+	+	++	
6	.....	....	..	—	—	+++	—	++	++	
7	Thigh	1	..	..	±	+++	—	+	—	Fig. 8
	Thigh	2	+	±	++	++	+	+++	+	
	Thigh	3	+	—	++	++	+	+	—	
13	Eyelid	2	..	..	+	+	+	+++	++	
12	Abdomen	1§	++	+	++	++	—	++	++	An increase of epithelial pigment is seen
	Leg	2§	++	++	++	+++	+	++	++	
13	Scalp	3§	+	++	++	+	+	+	+	

Explanation of Symbols: — = not noticeable; + = slightly noticeable; ++ = evident; +++ = very remarkable.

§ These eruptions, being from 2.5 to 3 mm. in size, are, for the sake of convenience, appended here.

There is an atrophy of the elastic fibers in the papillary layer. The infiltration is usually not evident in this stage.

(*b*) *The Peripheral Border.*—Examined in vertical section, the peripheral border exhibits, in well pronounced cases, conical prominences which chiefly consist of an overgrowth of the corneous layer showing usually a parakeratotic condition. The underlying epithelium becomes depressed allowing, in its utmost degree, the rete to atrophy, occasionally in association with its proliferation, which is commonly marked around the keratotic wall. Consequently, an irregularity in arrangement of the rete is to be seen.

The cell infiltration and pigment accumulation in the papillae, which are frequently elongated, are, as a rule, more intense at the border than in the center of the plaques. The furrow or sulcus, existing on the crest of the horny wall, may occur as a result of a partial detachment of the hyperkeratotic and parakeratotic projection.

(*c*) *Pathologic Changes of the sweat-glands and hair-follicles in the porokeratotic plaques.*

(1) Hair-Follicles: At the orifices of the hair-follicles there occurs more or less marked hyperkeratotic or parakeratotic thickening of the corneous layer, not infrequently in form of conical plugs or depressions, marking the sites of the follicles, whereby the orifices of the latter become funnellike or cylindrically dilated (Figs. 9, 11, and 12). Beneath the horny plug, obstructing the mouth of the follicle, there appears at times a cystic space in the follicle.

Sebaceous gland, hair-bulb and papilla are unaffected in the early stage, though later undergo atrophic and destructive changes. Enlargement of the sebaceous glands was not observed.

In the neighborhood of the keratotic follicle there is usually more or less marked round-cell infiltration, accompanied by a variable amount of pigmentation.

(2) Sweat-Glands: The sweat-ducts are, not infrequently, implicated in the keratotic process.

In the earliest stages of development, the sweat-glands in the plaque do not exhibit any sign of pathologic changes. Later, obstruction or disappearance of the terminal course of the ducts takes place, frequently followed by cystic dilatation of the remaining portion of the duct (Figs. 12 and 16), resulting in the atrophy or hypertrophy of the epithelial coat. The glomerulus may be unaffected for a long period. Indeed, it may apparently be intact even if the canalization of the duct is completely obstructed; the dilatation takes place after an entire disappearance of the peripheral duct.

Several writers described somewhat similar cystic dilatation of the sweat-duct occurring in certain pathologic conditions (Unna, Joseph,

Lebet, Pinkus, etc., and Shidachi). Whether the hydrocystomatic condition is to be regarded as a result of the mechanical obstruction or of the inflammation occurring at the peripheral course of the sweat-duct, is, in the opinion of authors, an open question. We do not possess suitable preparations to enable us to answer this interesting question. Both probabilities may be considered in the case of porokeratosis.

(3) Follicles and Sweat-Ducts at the Peripheral Border: The relation of the horny overgrowth or plug at the border, to the orifices of the skin glands, was carefully studied in serial sections. Indeed, at times it was seen that the horny accumulation occurs at the sites of the openings of the sweat-ducts or follicles taking part in the formation of the horny wall. This finding is not surprising, because the porokeratotic plaque tends to show a steady centrifugal extension. This also applies to the plaques on the sole in Case 1.

(4) Comedolike Horny Plugs: In the typical porokeratotic plaque, at its center as well as at the border, there are frequently minute comedolike horny plugs or depressions, which are regarded by Mibelli, Respighi, etc., as cornified sweat pores. Careful examinations show, however, that the minute comedolike horny plugs are nothing more than keratotic follicular orifices. This finding is completely in harmony with clinical observation. At times, particularly in late stages of development, there is difficulty in finding, histologically, the lanugo hair in the keratotic follicle, which is likewise atrophic; occasionally, the plug may not contain any trace of lanugo as can be easily understood from Figure 12.

To avoid error in distinguishing the cornified orifice of the follicle from that of the sweat-duct, examinations in serial sections are absolutely necessary. To my knowledge, horny plugs occurring at the mouths of the sweat-ducts are usually less pronounced or scarcely visible on account of their small size, though this may not apply to the sweat-ducts of the palms (compare No. 37 in literature).

Case 11 shows the keratotic condition at the orifices of the follicles and sweat-ducts very distinctly, appearing in two entirely distinguishable formations; the larger comedolike horny plug being follicular while the smaller exhibit the poral hyperkeratosis.

(3) INFILTRATION AND PIGMENT.—An inflammatory change in the superficial layer of the corium occurring in the porokeratotic plaque has been mentioned by some writers, namely, Mibelli, Respighi, Joseph, Kullack, Gilchrist, Wende, Himmel, etc.

In the vast majority of my cases well marked cell infiltration is to be noticed in the papillary layer, around the keratotic follicles and the border of the plaque. As a rule, more or less pronounced infiltration is to be seen in the primary efflorescences regardless of the degree of

the keratotic change. In the infiltration, mast cells are present but not evidently increased in number. A certain number of giant cells are found in one case (Case 7, No. 4).

Histologists differ in their views as to whether the primary disturbance is in the epidermis or in the corium. Mibelli, Reisner, etc., considered the inflammatory changes occurring in the upper layer of the corium as of secondary nature. The fact, however, that the almost constant presence of cell infiltration, which is well pronounced even in a slightly keratotic primary efflorescence, is in favor of the view that the disease is inflammatory in nature. At times, the inflammatory feature is so striking that it bears a certain resemblance to eczema marginatum, as was seen in Case 13.

In addition to the infiltration there is usually more or less marked deposition of pigment in the primary lesion as well as in the developed plaque. An exact description dealing with the pigmentation does not exist in the literature.

RÉSUMÉ

Mibelli considered the most characteristic finding of the disease to be the keratotic change at the sites of the sweat-orifices. He maintained that the disease has its beginning, in all probability, in the sweat-ducts, implicating by its peripheral extension particularly the orifices of the ducts. Though contrary views soon appeared in the publications of Respighi, etc., Mibelli still insisted on his opinion.

The views of Mibelli, who explained the pathology of this hitherto undescribed dermatosis so clearly, have been accepted by many dermatologists and quoted in the vast majority of the textbooks. That the dermatosis frequently exhibits a marked keratosis at the sites of the sweat orifices is true; and why should we doubt his findings concerning the sweat-ducts, which were subsequently proved by other writers to be correct? But, at the same time, he wanted to carry out a more careful examination regarding the changes of the follicular apparatus.

The present research throws some light on the histopathology of the disease. Histologic examination was carried out systematically in quite a number of the efflorescences in the early and late stages of development. It was seen that the keratotic change of the follicle is not rare at all. In fact, it is well marked in the majority of cases. The follicular hyperkeratosis, however, is not a constant occurrence in the disease. The same is the case in poral keratosis, which may also be a feature of some other dermatoses.

At any rate we are not justified to assume that the follicles are implicated in the process to a less extent than the sweat-ducts. The openings of the follicles as well as the sweat-ducts are similarly affected in their keratotic manifestations by the steady expansion of

the plaque, whereby the change occurs practically in the same manner (hyperkeratosis and parakeratosis in the follicular openings, with formation of horny plugs resulting in the obstruction and dilatation of the follicles; hyperkeratosis and parakeratosis at the sites of the sweat-duct orifices followed by obstruction, later dilatation). The other parts of the epithelial surface are likewise implicated in the keratotic change.

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EXPLANATION OF THE FIGURES

Fig. 1, a and b.—Showing the localization of the porokeratotic plaques on the chest, upper and lower extremities of Case 1.

Fig. 2, a and b.—Showing the localization of the plaques of Case 2.

Fig. 3, a and b.—Showing the porokeratotic plaques on the lower extremity. Case 1.

Fig. 4.—Showing the plaques on the back and arm. Case 2.

Figs. 5 to 16.—F, follicular keratosis; s, poral keratosis; w, so-called "wall"; I, cell infiltration; p, pigment; T, sebaceous gland; L, lanugo hair; C, cystic space; H, dilated sweat-duct.

Fig. 5 (Case 1, No. 8).—Note the infiltration in the subpapillary layer, with pigment deposition, epidermis being nearly normal.

Fig. 6 (Case 1, No. 7).—Slight keratosis at the mouth of follicle and sweat-duct. Trace of wall will be seen.

Fig. 7 (Case 4, No. 3).—Around the keratotic follicle and in the superficial layer of corium, evident infiltration in association with pigmentation.

Fig. 8 (Case 7, No. 1).—In this efflorescence the keratotic follicles play an important rôle.

Fig. 9 (Case 7, No. 4).—Beneath the plug there is a cystic space.

Fig. 10 (Case 13, No. 6).—Note the infiltration near the peripheral wall. Also, perivascular infiltration in the subpapillary layer. Hyperkeratosis and acanthosis will be seen in the plaque.

Fig. 11 (Case 1, No. 17).—Showing highly keratotic follicles. Perifollicular infiltration.

Fig. 12 (Case 1, No. 18).—The mouth of the follicle is cylindrically dilated by horny plug. Lanugo becomes pressed.

Fig. 13 (Case 1, No. 18).—Atrophy of the rete will be noticed. Clinically there was atrophic change of the skin.

Fig. 14 (Case 11, No. 4).—Showing keratotic follicles and sweatpores.

Fig. 15 (Case 1, No. 23).—Vertical section of the furrow at the peripheral wall of the plaque on the sole. Marked hyperkeratosis and irregularity of papillae. Perivascular and diffuse infiltration in the papillary and subpapillary layer.

Fig. 16 (Case 1, No. 22).—Vertical section of the wall of the plaque on the sole. The crest of the wall exhibited a continuous furrow (compare literature No. 37, picture of the sole of this patient). wR, a part of the wall; wB, the furrow along the wall.

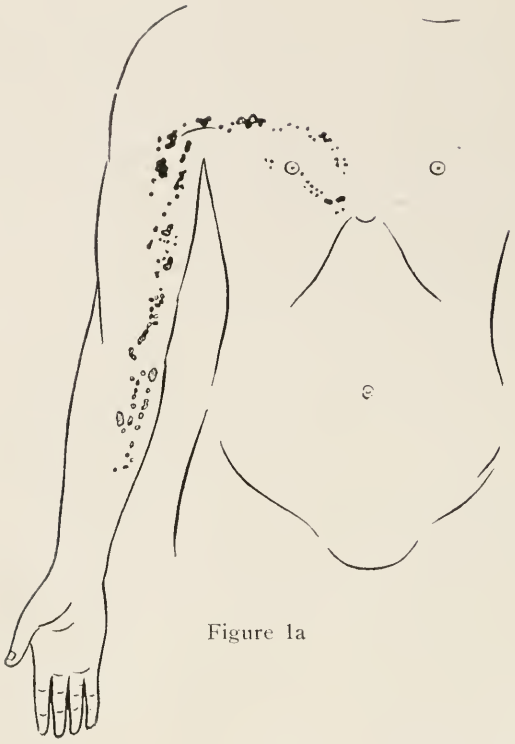


Figure 1a

Figure 1b

Figure 2a

Figure 2b

Figure 3a

Figure 3b

Figure 4

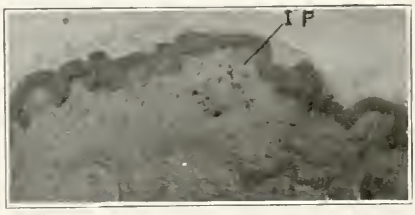


Figure 5

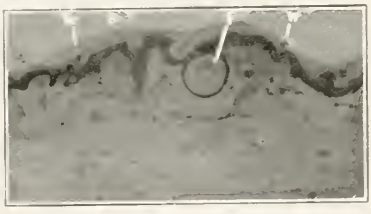


Figure 6

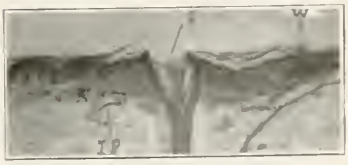


Figure 7

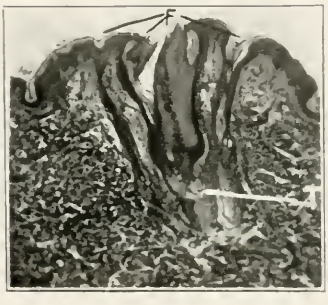


Figure 8

Figure 9

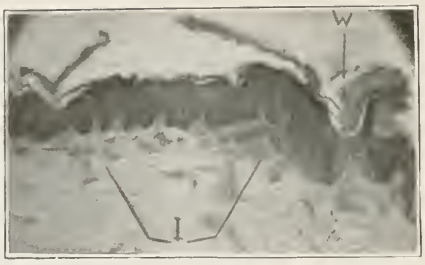


Figure 10

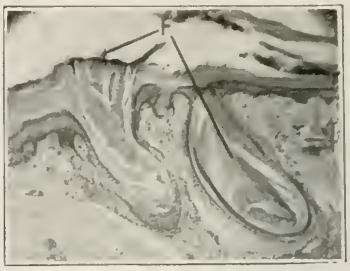


Figure 11

Figure 12

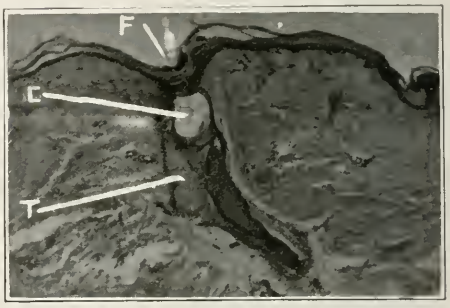


Figure 13

Figure 14

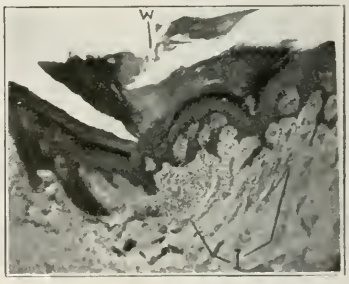


Figure 15

Figure 16

Clinical Report

ANNULAR MACULAR SYPHILIS

REPORT OF A CASE OCCURRING AS AN EARLY SECONDARY MANIFESTATION

JOHN J. ROTHWELL, M.D.
NEW YORK
From the Department of Dermatology, New York University (University and Bellevue)

The case which forms the subject of this report presents features which, while they may be confirmed by textbook descriptions of this syphilid are worthy of note because of the time of their appearance and the nature of their response to treatment.

REPORT OF CASE

History.—The patient was a white man, aged 29, teamster by occupation, born in the United States. He presented himself at the University and Bellevue clinic, Nov. 12, 1917, with a double chancre on the dorsum of the penis, double inguinal adenopathy, enlarged epitrochlear and cervical glands, and stated that he had received nine intramuscular injections. He did not know just what medicine had been injected, and our inquiries led us to believe that it had been either mercury or possibly venarsen, at any rate, not salvarsan or arsenobenzol. In reply to the routine questioning, he acknowledged the occurrence and presence of an eruption at the time.

Examination.—Before completely exposing the patient for examination, his arm was bared for the taking of blood for a Wassermann test, and there was observed an apparently frank eruption of erythema multiforme on the thin skin of the flexor and ulnar side of the forearm; the lesions were circinate, not pruritic, purely erythematous (fading on pressure and directly reappearing), the circles measuring 1 to 2 inches in diameter, with quite definite borders measuring from one-eighth to one-fourth inch in width. On completely exposing the patient the eruption was found to be distributed over the trunk, arms, forearms, hips and thighs, and of similar character to that on the forearm, excepting that the circles on the trunk in some instances were of as large diameter as 3 inches. The lesions were without infiltration, purely macular, faint pink in color, and the centers were clear of any but the normal pigment of the rest of the uninvolved skin.

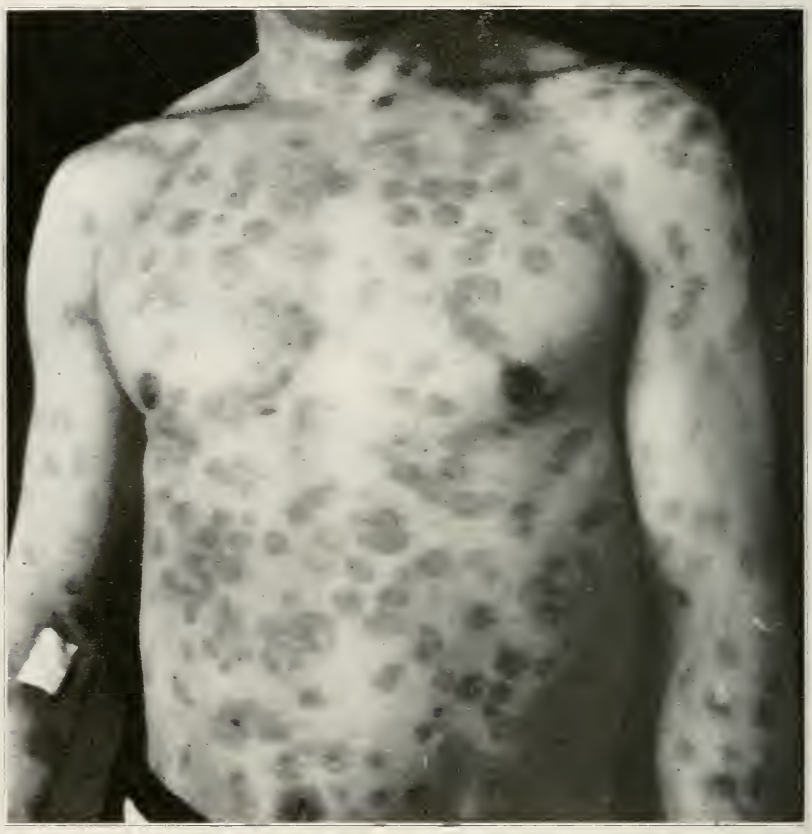
Clinical Features.—The clinical appearance was that of an erythema multiforme, there being no scaling whatever; over the chest region, however, there were observed in the center of each of two of these circinate lesions a brownish-red papule of about pea-size.

The history given was that the eruption had appeared about six weeks after the appearance of the primary lesion, and that the skin lesions were of about the same size and appearance as at the time of our observation. (It is probable that the lesions had appeared, without the patient's knowledge, as the

ordinary faint, finger-nail sized macules, and had enlarged and become apparent to him after a lapse of time.) The patient did state, however, that he had noticed the gradual clearing of the lesions.

TREATMENT

As it was inconvenient at the time of his first visit to the clinic to photograph the case, treatment with mercury by mouth, and arsenobenzol by intravenous injection was begun and the accompanying



A case of annular macular syphilis which so closely resembled a clearly defined condition of erythema multiforme as to make the differential diagnosis by objective symptoms alone very confusing.

photograph was taken two weeks after this first visit. In the photograph there will be noticed the presence of more than two circinate erythematous lesions containing central papules. These additional papules made their appearance as the erythematous lesions had faded, and while in the photograph the erythematous lesions show as well marked skin lesions, under the two weeks' treatment with mercury and two intravenous arsenobenzol injections there had been so marked a

change for the better that it was feared a photograph would no longer satisfactorily show the definition of the erythema element.

COMMENT

A case of annular macular syphilid is reported by Howard Fox[1] with a review of the literature on the subject and a photograph showing the lesions.

In this article, he notes that while the textbooks describe the occurrence of the eruption, there is quite a general agreement on the point that this peculiar manifestation appears in the late secondary or even tertiary period of the disease; that while the textbooks make mention of the occurrence, probably the description is not made from first hand observation; and that considering how few such cases have been reported in the literature it is an unusual manifestation of the disease.

The paper was read by him at the meeting of the American Dermatological Association, Washington, D. C., May 8-10, 1916, and in the discussion which followed Dr. Hazen spoke of the resemblance of all three of his cases of this lesion to erythema multiforme and of the occurrence of the eruption two years after infection in the first case, four months after infection in the second and six months after infection in the third case. Dr. Ravogli in this same discussion stated his observation of the eruption at about the end of the first year and sometimes in the second. While the eruption in the first of Dr. Hazen's cases had cleared up in about three weeks under the administration of "mixed treatment," Dr. Ravogli remembered the eruption to have remained for some time.

There is enough of the unusual in the case to merit observation of a point or two. So clearly definite a picture of erythema multiforme (except for the presence of the two pea-sized papules) was presented that a diagnosis from objective symptoms alone might easily have been incorrect. One is prompted to suggest the advisibility of a Wassermann examination in a case of supposed persistent erythema multiforme, especially in the female, genital lesions in this sex so often escaping observation. Another point worthy of recollection is that there was a rapid disappearance of the eruption under usual treatment (as in Dr. Hazen's first case) as opposed to the usual belief that the annular macular syphilid may be resistant to treatment.

No spirochete examination was made, the indurated genital lesion, the adenopathy, and the eruption with its two very suspicious papules making a diagnostic picture, amply sufficient to warrant the institution of antisyphilitic treatment for the sake of gaining time in getting the disease under control, until the Wassermann report (one week later) should be known. The Wassermann proved to be ++++, and the patient responded rapidly to treatment.

1. Fox, Howard: THE JOURNAL CUTAN. DIS., April, 1917.

Society Transactions

NEW YORK DERMATOLOGICAL SOCIETY

Regular Meeting, Nov. 27, 1917

CHARLES MALLORY WILLIAMS, M.D., *President*

CASE FOR DIAGNOSIS. Presented by DR. G. H. FOX.

The patient, a man aged 58, was from Havana, Cuba, and showed an interesting and well-marked eruption, which had lasted for three years. At the hospital in Cuba it was diagnosed as lepra, and the man had in consequence been greatly worried and had lost much flesh on that account. The eruption consisted of innumerable papular elements, approximately lentil-sized, affecting chiefly the trunk and extremities. The lesions were oval and circular in shape, reddish-brown, smooth, free of scales and slightly infiltrated. There were also several large plaques, especially one on the lower part of the back, presenting a slightly raised, smooth, reddish surface, irregularly circular in shape, with a depressed, lighter-colored, sunken area in the middle of the patch. The central portion appeared like a retraction or shrinking of the skin in the interior of the plaque. There was no anesthesia; there was a little erythematous patch over one eyebrow, but it was not infiltrated and there was no swelling of the hands as in early lepra, nor was there the atrophy that one would expect at a later stage. The speaker said that he saw no indication of the dermatosis being lepra. Nor did the eruption seem to be syphilitic, in spite of its resemblance at first glance. The Wassermann reaction was positive, but the man had suffered from this condition for three years and there had been no involution of any of the lesions and no other indication of syphilis.

Another possible diagnosis was mycosis fungoides. There were some large patches on the back which suggested that condition, but there was no itching and no tumor formation, and that diagnosis would seem to be ruled out. One competent dermatologist who saw the case thought that it was a new growth, possibly sarcoma. There was a decided purplish color to the eruption, very clear in the day time but not so evident by artificial light. The lesions on the hands were very dark, almost blackish, but not nodular or notably infiltrated. There was a good deal of hyperemia connected with the eruption, and the speaker was inclined to consider it an inflammatory condition and not a neoplasm—possibly chronic lichen planus.

Dr. Heimann had made a biopsy of this case, but had not yet reported on it, so this was a good opportunity to make a clinical diagnosis. There were no lesions in the oral cavity. From the legs down there was a little eruption like an atrophic eczema. If it were a case of pigmented sarcoma one would expect to find well-marked lesions below the knees.

DISCUSSION

DR. TRIMBLE said that he would hesitate to give a definite opinion on such an unusual case. The large areas of dusky red, thickened skin with accentuated lines on the back presented some of the characteristics of mycosis fungoides. He could not now recall any other disease that would produce such plaques. The small scattered papular lesions, however, did not resemble that condition. The only other thing that he could think of was one of the types of leukemia of the skin; the eruption might fall into the group of cutaneous manifestations that accompany some form of that disease. Such conditions were rare and very vague, and few of us had seen many of them. The positive Wassermann

was in his opinion a mere coincidence; the eruption did not bear much resemblance to any of the well known cutaneous syphilids. He might have a positive Wassermann from an early infection of syphilis and some other skin affection later in life.

The fact that he had been in the Havana institution and there diagnosed as leprosy, together with the positive Wassermann, were the only reasons to make one suspicious of that condition; the eruption did not look like lepra. He would await the result of further study of the case with much interest.

DR. HEIMANN said that after Dr. Trimble's remarks there was little to add. The case was unique in that it presented so many features of so many diseases, and nothing definite of any one. The first thing that occurred to him was that clinically it suggested mycosis fungoides more than any other possibility. As for the closely related leukemids, the absence of itching ruled them out. The same applied to the possibility of lichen planus. It was almost impossible to conceive of so extensive a lichen without pruritus. The clinical features of leprosy seemed to be wanting. In generalized sarcoma, the lesions would be more waxy and solid to the touch than these were. Either mycosis or premycosis might be considered, together with the parapsoriasis group. He had an intuitive feeling that it was a mycosis fungoides.

DR. WISE said that he could not agree with Dr. Fox's diagnosis of lichen planus, and was inclined to class the dermatosis in the group of benign sarcomatosis of the skin.

DR. SHERWELL said that the only suggestion he could offer was to let therapy partially make the diagnosis. He would give the patient antisyphilitic treatment and see if that cleared up the matter partially or totally; also the roentgen-ray might help to solve the problem. To him it looked more like sarcoma than anything else.

DR. LANE said that he would not venture to make a diagnosis, although the appearance was that of mycosis fungoides rather than that of lichen planus. He could see nothing suggesting leprosy. He had noticed one thing which had not been mentioned, which led him to think that possibly there might be some internal lesions. The greatly enlarged superficial veins of the left arm suggested that there might be some obstruction of the deeper veins in the arm.

DR. SHERWELL remarked that the man told him he had never been treated antisyphilitically.

DR. KINGSBURY said he thought that it was high time he had such treatment.

DR. MACKEE said he had no diagnosis to offer, but that he did not think it was lichen planus or leprosy. He could not get any closer to a diagnosis than Dr. Heimann and the other speakers. He hoped that the histology would be definite.

DR. FOX said that the patient would be delighted to learn that no one supported the Cuban doctor's diagnosis that it was leprosy. The spot on the forehead and another one did suggest leprosy, but the absence of anesthesia and enlargement of the ulnar nerve, together with the lack of any numbness in the hands would rule out leprosy.

Although it had very much the appearance of a typical syphilid, the fact that three years had passed without any disappearance of any of the lesions, the large infiltrated patches, no tendency to annular eruption or mucous patches, would incline him to exclude syphilis regardless of the Wassermann reaction.

As to mycosis fungoides, many of the large patches very much resembled that condition; on the other hand, he had never seen a case of mycosis fungoides lasting for three years with such numerous lesions on the body and no itching. There was no tendency to tumor formation, which would be apt to show after three years.

The diagnosis of sarcoma had been suggested; a microscopic examination would reveal whether the condition was inflammatory or a new growth. If it was a new growth, he would be inclined to consider it to be sarcoma rather than mycosis fungoides. The notable purplish hue of the eruption and the large number of hyperemic papular lesions, both isolated and in groups, had suggested the diagnosis of generalized lichen planus. Some of the lesions, if not typical lichen planus papules, were flattened and umbilicated and as much like them as in many cases that were so diagnosed.

FAVUS. Presented by DR. HEIMANN.

The patient was a little girl, aged 13, born in this country of Russian-Jewish parentage. Three months ago she developed favus over the left breast, and then above that area, she developed three distinct types of lesions: one a ringworm type; another, of the scutulum type; and a third consisting of minute, red, pinpoint lesions resembling lichen scrofulosorum. The case was an interesting demonstration of the beginning and development of favus lesions. It was of still further interest because it developed in this country, and no other member of the family had had anything of the kind. The speaker said he had only that morning heard that the little girl had acquired the infection while in a camp where she was with some thirty other children.

DISCUSSION

DR. LANE said Dr. Heimann had remarked that the case was interesting in that it had developed in this country. He himself had seen some fifteen cases of favus in New Haven, every one of them occurring in children born in this country; all were Italians. Very likely it was carried to them by some adults that brought it in, but all the cases were in native children, and he had not yet seen a case which had developed in a foreign country and had been imported.

DR. WISE suggested the inoculation of a domestic mouse to see whether it would become infected with scrapings from the lesions.

DR. SHERWELL said that he had seen this affection in the lower animals—dogs and mice, and had written a paper on the subject (American Dermatological Association, 1892). One case developed in Brooklyn, another in a Long Island villa residence. The pet dog in the last mentioned instance had caught some field mice so affected, played with their bodies, and had acquired the trouble. He then infected two daughters of the house on the neck and face. The speaker sent some of the dead mice to Professor Unna, Hamburg, and he expressed himself much gratified to have them. Also some were sent to G. Behrends, Berlin, both of whom made microscopic examinations and found the same organism. Unna gave a long description of his findings in THE JOURNAL about that time. Another lot of cases, also in mice, were seen in the city home of a well known jurist of Brooklyn. It was most marked in their ears and the irritation therefrom was such that they got crazy—would run up the curtains, etc., and allow themselves to be caught by hand. This might have been the source of infection in the girl presented by Dr. Heimann. She was in a camp where such animals might have been.

DR. FOX said that forty years ago he had photographed a beautiful little girl whose body was covered with small reddish discs. At first it was regarded as a case of tinea tonsurans maculosa, but in a week or two minute yellow crusts began to appear and it proved to be a typical case of favus.

DR. HEIMANN said that mouse favus ran a different course in human beings from that presented in this case. It caused lesions like an ordinary pustulovesicular ringworm, and the actual fungus was determined only by cultures with Sabouraud's medium.

ATROPHIA MACULOSA WITH DENSE SURROUNDING PIGMENTATION. Presented by DR. TRIMBLE.

The patient was a young woman, aged 20, single. Nativity, Russia. She had been shown at the previous meeting by the speaker, as a peculiar pigmentary condition of the neck, resembling the pigmentary syphiloderm. At a subsequent examination the white lesions scattered through the pigmentation were seen to be undergoing very slight changes of an atrophying character; so there did not seem to be any doubt about the condition being one of atrophy, in addition to the pigmentation.

DISCUSSION

DR. G. H. FOX said he was convinced that this was not a case of vitiligo nor the vitiligoid syphilid, for the spots were not smooth and round, but wrinkled and of irregular form. He had seen a number of such cases which he had diagnosed as morphea before the white spot disease was described, and he thought this eruption was allied to morphea, though not a typical case.

DR. HEIMANN said that when the case was presented he had thought it an ordinary case of pigmentary syphilid, but that he was now forced to change that view and agree with what Dr. Fox had said.

DR. MACKEE said that he knew of no disease that would produce white, oval, atrophic, depigmented macules, surrounded by hyperpigmentation. Until further study, he was inclined to agree with Dr. Fox that the case was one of anomalous white spot disease, probably at or almost at the end of involution.

DR. TRIMBLE said that he had brought the patient back because when she had been shown before, only one or two of the members said anything about the atrophy; it did not then show distinctly, but had developed markedly since then. There was no doubt now in his mind that it was atrophy of the skin; the type could be decided later.

CASE FOR DIAGNOSIS. Presented by DR. TRIMBLE.

The patient was a womn, aged 56. She presented immediately to the right of the middle line of the forehead a red linear lesion, about one-half inch wide, slightly infiltrated and extending from the hair line above, to the eyebrow below. It had existed for four months, and was accompanied by severe headache across the whole forehead. There had been no change in the lesion since its appearance, and no other subjective symptoms. The Wassermann reaction was negative. The urine was normal with the exception of a very slight trace of albumin. Blood pressure, 145.

DISCUSSION

DRS. HEIMANN, WINFIELD and WISE thought it was scleroderma.

DR. G. H. FOX thought that this would undoubtedly develop into the banded form of scleroderma.

DR. WISE said that Dr. Ludwig Weiss had shown a similar case, which he cured in about one year with thyroid extract and no other medication.

DR. SHERWELL said that he had referred a case to Dr. Johnston (on account of her residence being in New York) of the most extensive distribution of scleroderma he had ever seen, the face, upper and lower limbs, and trunk being affected. He had personally used in her case pituitrin, with, as it seemed, good results, and Dr. Johnston had continued the same with greatly increased dosage, more than the speaker had ever administered, and the condition was improving markedly.

MULTIPLE BENIGN SARCOID (BOECK). Presented by DR. TRIMBLE.

The patient, a male adult, white, aged 23, presented on the left malar eminence two nodular infiltrations adjacent to each other, the larger being about the size of a dime, and the other about three-eighths inch in diameter, with

pinkish or reddish borders, and yellowish or whitish centers. The color in the border disappeared largely on stretching the involved area of skin, the color of the center appearing white.

The family history was negative for tuberculosis.

The lesion started as a "pimple" eighteen months ago, and gradually increased in size without subjective symptoms. His wife and child were both well. The Wassermann test, Nov. 21, 1917, was negative.

CASE FOR DIAGNOSIS. Presented by DR. TRIMBLE.

The patient, a white woman, aged 29, presented on the bridge, sides and tip of the nose four areas of dusky red or brownish infiltrations, with borders elevated above the level of the involved and uninvolved skin and of a dull glistening character, the center of the larger lesions being sunken or depressed. The largest area, situated on the right side of the nose near the eye, was about 1 inch in its larger diameter and probably about one-half inch in its smaller dimension; it was the oldest and most developed lesion; its central portion was distinctly sunken. The smallest lesion was that on the tip of the nose, being about the size of a small pea, and did not show the central depression or absorption apparent in the other lesions, so that it appeared as a small flat nodule with a distinct border; the flattened surface of this small nodule was of lighter tint (yellowish or whitish) than the duller brownish color of the other lesions. There were no scales and no enlarged follicles. Telangiectases were apparent in the largest lesion. The duration was about two years.

Family History: The father died at 30 years of pulmonary tuberculosis. Otherwise the history was negative.

Personal History: The patient was always in good health except for typhoid fever, twenty years ago. The Wassermann reaction was negative. There had been slight scaling formerly which had disappeared after the use of ointments. The eruption had rarely itched and then not intensely.

DISCUSSION

DR. G. H. FOX said he would not like to make an absolute diagnosis, and he would not say that these were not cases of the sarcoid of Boeck, but the few cases that he had seen presented a tumor formation and were without the serpiginous condition which seemed to obtain in these cases, and he doubted if the diagnosis of sarcoid was justified in either instance.

DR. WISE said that the lesions of the man's cheek resembled granuloma annulare, and called attention to the fact that some authorities (notably Galewsky) included granuloma annulare in the sarcoid group. In regard to the patient under discussion (the woman) he thought the lesion might be one of Brocq's angio-lupoid.

DR. MACKEE said the angio-lupoid mentioned by Dr. Wise had been proven to be sarcoid.

DR. WINFIELD accepted Dr. Wise's diagnosis, and said that if the woman were his patient he would call it lupus.

DR. HEIMANN said that in the case of the man, the conditions that suggested themselves were the sarcoid of the Boeck type or atrophic lupus erythematosus, or morphea in the early stages. The second concept could be dismissed, for it had none of the characteristic features; morphea also could be dismissed. As to the choice of the various members of the other group, the distinctions made were largely meticulous, for they were closely related granulomas. He was inclined to sarcoid, for the lesions were not hard; it was more of an edema which reached its maximum at the margins than an infiltration, which would bring it back to the sarcoid group. On purely clinical grounds he was inclined

to consider the condition as being a sarcoid of the Boeck type—perhaps a disseminated lupus erythematosus.

The girl presented the same features and suggested the same line of thought; but coming as she had under treatment, the lesion looked more like the ordinary lupus erythematosus, and that would probably prove to be the diagnosis in her case.

DR. MACKEE said that one of the previous speakers had suggested the diagnosis of granuloma annulare in the case of the man. He disagreed with this diagnosis, because the lesions were too superficial and not sufficiently elevated or hard. Both on inspection and palpation, one gained the impression of slight infiltration and marked edema and vascularity, whereas the clinical impression in granuloma annulare was just the opposite. Furthermore, there was distinct atrophy, which was not a characteristic of granuloma annulare. Dr. Wise suggested a very close relationship between granuloma annulare and sarcoid. Clinically the two affections were distinct entities, and the anatomy also was dissimilar. In sarcoid the histologic structure was that of tuberculosis, while in granuloma annulare there was a diffuse infiltration with a very marked and characteristic degeneration of collagen. The speaker understood that in certain stages of evolution the histology of granuloma annulare suggested a tuberculid.

The diagnosis, clinically, in the man appeared to rest between sarcoid and lupus erythematosus, and while the speaker favored lupus erythematosus he could not exclude the sarcoid of Boeck. Certainly, it was not the sarcoid of the Darier-Roussy type as Dr. Heimann had suggested, because this type was very deep seated and resembled Bazin's disease.

In the case of the woman, the speaker was puzzled by the presence of the rolled edge as were also the previous speakers. The telangiectasis and atrophy of lupus erythematosus were present, but there was the smoothness and infiltration of sarcoid. The speaker was unable to make a definite clinical differentiation between the two diseases.

DR. TRIMBLE said that he had seen the man twice before, and the diagnoses that had suggested themselves were just those that had been given—sarcoid, morphea, lupus erythematosus and granuloma annulare, though the last was soon dismissed. Although the yellowish white color looked quite a little like granuloma annulare, the fact that the condition did not have the hard elevated border and depressed center seen in these cases caused it to be discarded. The main reason for rejecting the diagnosis of morphea was that it had no increased pigmentation at the edges and no telangiectases; that left lupus erythematosus and sarcoid to be considered.

He had never seen lupus erythematosus with a white infiltration like this. It did not seem to have any special features of lupus except the location and the fact that it had been there two years; there were no adherent scales, no patulous follicles and little redness; he was therefore inclined to call it sarcoid, the multiple benign type described by Boeck, and he agreed with Dr. MacKee in that the Darier-Roussy type of sarcoid was a deep seated lesion and not like the case presented. As for the woman, he confessed that a positive diagnosis was at this time beyond him. Naturally the first thought was lupus erythematosus, since a certain amount of scaling was present and since she had also several small outlying lesions. The large lesion had a depressed center and a peculiar waxy border, which seemed foreign to the ordinary case of lupus erythematosus. There was slight scaling at first, which had been relieved by treatment. It might yet turn out to be an ordinary case of lupus erythematosus, but the larger lesion had some indications of epithelioma; the elevated waxy border, the telangiectasis, and the depressed atrophic center suggested the morphealike epithelioma. The fact that there were sev-

eral lesions present, and many of the typical features of erythematosus lupus were absent, caused him to think that the case might be an atypical sarcoid.

LEPRA MACULO-ANESTHETICA. Presented by DR. WISE for DR. MACKEE.

G. P., a man, aged 30, a native of Greece, was from Dr. Fordyce's clinic. The duration of the condition was six years. The patient presented an early eruption of leprosy on his face and on the backs of his arms—the eruption being of a peculiar brownish, mottled character. On the face there were several smooth dusky red plaques, most pronounced over the eyebrow region. The eruption on the arms was entirely macular and presented a condition similar to cutis marmorata. Anesthesia was pronounced and the ulnar nerves were enlarged.

SYPHILODERMA, WITH KELOIDAL SCARS. Presented by DR. HEIMANN.

The patient, J. E., was a young man from Dr. Fordyce's clinic, with a primary lesion on the penis. A year ago, when he first came to the clinic, he had a rapidly developing syphiloderm with all the symptoms of scars, etc., and two keloid scars on the left arm. He had been treated at the clinic with mercury and locally with a white precipitate ointment. He was presented on account of the various types of lesions still remaining, especially the keloid and other scars.

FOR DIAGNOSIS (ATROPHODERMA). Presented by DR. WISE for DR. FORDYCE.

The patient, C. R., was a man aged 50, born in Germany, who had been in the United States for thirty-five years. The disease had been of five months' duration. The exhibitor thought it would be better to present the case for diagnosis, as the patient showed lesions which were of rather unusual interest. The duration was said to have been five months, but presumably it had been longer, judging from the appearance of the lesions on the chest, which were atrophic in character and in which the hair follicles were not only prominent but hyperpigmented, whereas the surrounding skin seemed to be depigmented. There were also numerous lesions on the back, chest and abdomen, which were distinctly erythematous and acute in character. On the thighs there were several lesions, more or less atrophic and somewhat sclerodermatous, or a combination of both.

At first sight the erythematous lesions on the back resembled those of early mycosis fungoides or leukemia cutis. Itching was intense. A blood count, submitted by Dr. Vogel, of Columbia University, revealed the following: Polymorphonuclears, 57½ per cent.; lymphocytes, 23 per cent.; transitionals and large mononuclears, 4 per cent.; eosinophils, 14½ per cent.; basophils, ½ per cent.

The possibility of early leukemia or Hodgkin's disease was suspected.

XERODERMA PIGMENTOSUM. Presented by DR. WISE for DR. MACKEE.

The patient, A. P., a little girl, aged 7 years, was born in the United States of Italian parentage. She came from Dr. Fordyce's clinic and had been seen for the first time the day previously. The duration of the trouble had been five years. The family history was negative. She presented a large number of freckles on the arms and legs, and on the face and neck, with keratoses. There were no atrophic pits, such as were sometimes seen, and very few telangiectases. She presented an epithelioma of the right ala of the nose, with numerous verrucae on the face. She had opacities of both eyes. The other children of the family were living and healthy.

CHICAGO DERMATOLOGICAL SOCIETY

Regular Meeting, Nov. 20, 1917

WILLIAM A. PUSEY, M.D., *President*

(*Continued from p. 378*)

PELLAGRA. Presented by DR. HARRIS.

The first patient was a woman, aged 40, a seamstress by occupation. She complained of pain in the epigastrium, nausea, vomiting, diarrhea, loss of weight and weakness. The onset of the gastric symptoms was two years previously. Diarrhea had been present for three months. Personal and family history negative. Test meal and roentgen ray showed evidence of carcinoma. Her diet consisted almost entirely of turnips, beets, cornmeal mush, crackers, bread and soup occasionally; no meat. She was becoming mentally duller and more apathic.

The second patient was a man, aged 43, by occupation a porter in a saloon. He complained of itching, excoriations and pediculi were present. The teeth showed pyorrhea and carious processes; the tongue was reddish with a raw margin. The skin of the dorsum of the hands was atrophic, with brownish pigmentation, a typical case of "gloved-hand." The symptoms consisted of diarrhea (involuntary evacuations), lassitude, hallucinations and disorientation. He was on dietetic treatment. The pellagrous symptoms cleared up under dietetic treatment except that the mental condition was still far from normal.

DISCUSSION

DR. PUSEY said he had seen a case of pellagra develop right under his eyes. The patient had an epithelioma on the tip of his nose and while under treatment for that developed what the speaker considered an erythema multiforme on the backs of his hands. This went on rapidly at first to a frank case of pellagra. It subsided with cold weather very much as this man's had, to recur the following summer. This patient lived in very comfortable circumstances.

DR. HARRIS recalled the case of a little boy, who had appendicitis and had been on special diet and developed the disease. The woman patient shown here had been on a diet of tea and toast for some time before pellagra developed. He thought the disease was a result of a monotonous diet.

CHANCRE OF THE LIP. Presented by DR. MCEWEN.

This patient was presented at the last meeting and was shown again because he had developed an area of necrosis about the lesion and there had been no improvement under treatment.

DISCUSSION

DR. FISCHKIN thought it might be a soft chancre and a hard chancre mixed. He thought the antisyphilitic treatment the man had been receiving had healed up the syphilitic manifestations of the disease and that what was left was a soft chancre.

DR. HARRIS stated that after being shown at the last meeting the man developed an area of necrosis. He thought it was a very badly infiltrated chancre with possibly a secondary infection from the secretions of the mouth.

DERMATITIS HERPETIFORMIS VEGETANS. Presented by DR. HARRIS.

The patient was a man, aged 39, by occupation a waiter. This patient had been shown many times during the last five years. He was shown now because he was having a new attack and showed the vegetative type of lesions.

FOLLICLIS. Presented by DR. HARRIS.

The patient was an obese man, aged 27, a teamster by occupation, single. The onset of the disease occurred eight years previously. The lesions consisted of reddish papules on the legs which became necrotic and healed in

about three months, leaving a pigmented scar. A lesion appeared on the penis six months later. The lesion on the penis had never healed completely and had destroyed most all of the glans. The lesions on the legs had come out in crops. At one time the patient was in the hospital with a typical Bazin's disease and at the same time showed the folliclis. The Wassermann reaction, June 28, 1917, was ++ positive; six Wassermann tests previously had been negative. The patient had received many salvarsan injections as well as much other antiluetic treatment with no result.

DISCUSSION

DR. FISCHKIN thought the scars on the legs were typical of syphilis.

DR. HEIDINGSFELD believed it was a tuberculid of the skin.

LEUKOPLAKIA BUCCALIS. Presented by DR. FISCHKIN.

The patient was a man, aged 34. There was no history of syphilis or tuberculosis; he was married and had five healthy children. In the inner surface of the left cheek, on a line tracing the conjunction of the upper and lower teeth there was a band of aggregated plaques, fissured and elevated above the surface of the mucosa, of a dull brown color. At about the distal third of the line the mucosa became much thinner, hyperkeratotic with characteristic grayish (nitrate of silver) color. At the commissure the leukoplakia branched off to the upper and lower lips, stopping at about the middle of the lip. On the upper lip near the commissure was a small superficial ulcer with soft base and edges covered with a crust. The mucosa of both lips was highly atrophic, in places granular.

DISCUSSION

DR. PUSEY thought it was a case of leukoplakia, a condition which produced various sorts of pictures in the mouth.

MELANOTIC CARCINOMA. Presented by DR. MACKEY.

The patient was a man, aged 25, who smoked cigarettes immoderately. The lesion appeared about three years previously, becoming more extensive about one year ago. It consisted of an ulceration about the size of a peanut shell with a large amount of pigmentation involving the region of the hard palate and extending down to the gum line on the left side.

DISCUSSION

DR. ORMSBY believed it was an epithelioma, but could not account for the pigmentation.

DR. FOERSTER was reminded very forcibly of bismuth pigmentation of the mucous membranes seen in the Children's Hospital following the use of bismuth paste. There were light gray lesions with distinct irritation of the mucous membrane, such as was seen in bismuth pigmentation, but on closer inspection it looked like a malignant growth. He thought in this case the pigmentation might possibly have been produced by nitrate of silver, as black areas sometimes occurred from that.

DR. FISCHKIN stated that one should think of the possibility of the pigment having been there all the time.

DR. PUSEY was of the opinion that the central lesion was malignant, probably carcinoma, but he was not inclined to believe that all the pigmented area represented carcinoma. He had seen several cases of lesions on the lip or in the mouth where pigmented areas appeared and gradually enlarged; and this patch looked very much like the same sort of process. He had seen these pigmented areas appear, persist for several months and then disappear. They were not necessarily malignant.

BLASTOMYCOSIS (GENERALIZED). Presented by DR. ORMSBY.

The patient was a man, aged 41, and the duration of the disorder was fifteen years. The first lesion occurred on the internal surface of the right thigh. The disorder gradually spread until the area depicted in the photograph became involved. During the last year and a half evidences of systemic involvement had been presented.

Another point of interest was the fact that during the last two and a half months great improvement had occurred through the administration of six injections of salvarsan. Previous to this, under potassium iodid and other measures, the disease had continued to progress.

BLASTOMYCOSIS. Presented by DR. STILLIANS.

The patient was an American woman, aged 25, who presented lesions which had been present constantly for thirteen years. She was shown because of recurrence under heavy doses of iodid and after treatment with roentgen rays. The roentgen rays had reduced the size of the tumors remarkably, but recurrences had taken place at the borders of the remaining lesions and in the scars of lesions apparently healed.

DERMATITIS REPENS. Presented by DR. ORMSBY.

This patient was shown at the previous meeting and was exhibited again to show the lack of response to the treatment.

The treatment employed during a period of three months included two injections of salvarsan and tonics internally. Locally, for varying periods, the following ointments: Wilkinson's, a strong ammoniated mercury, a 10 per cent. ichthyol, and at intervals a soothing cream. Wyeth's iodin petrogen gave temporary relief. Dakin's solution was used for some time without result. One period of roentgenotherapy was given and at present the quartz light was being employed.

DERMATITIS REPENS (?). Presented by DR. MCEWEN.

The patient was a man, aged 50, whose trouble had been present for two weeks. The lesions began as vesicles involving the dorsum of both hands and fingers and extending over the forearms; the skin was undermined and raised and maceration was very evident. On the body there were definite discrete elevations, resembling wheals, but clearing in the center. In some instances scales had formed over them and they had fused. There were no objective sensations on the body.

A pure culture of *Staphylococcus aureus* had been obtained from the vesicles.

DISCUSSION

DR. LIEBERTHAL asked if the ultraviolet rays had been tried and suggested that they be used in this case.

DR. MCEWEN was of the opinion that the category of dermatitis repens was being extended to include parasitic eczemas.

DR. STILLIANS mentioned the fact that Sutton had found *Staphylococcus aureus* in all the cases he called acute dermatitis repens and that was the only organism found in the fresh bullae in the case presented.

DR. ORMSBY believed the lesions on the neck were of the same character as those on the hands, though they were more dry and did not exhibit the same tendency to recurring pustulation. The feature that impressed him most in all of these cases was their persistence in the majority of patients. Treatment that was successful in ordinary infections of the skin had no effect in these cases. Crocker thought there was a neuritic element present together with some infection. The case presented probably showed a picture described by Hallopeau under the title "acrodermatitis perstans." The distinction between

this and dermatitis repens was difficult to make. The constant recurrence of pustules all over the affected area together with lesions on the body was more characteristic of Hallopeau's than of Crocker's dermatosis. From independent observation it would seem that distinctions could be made and a study of the disorder was indicated for its proper placement. Simple cases of dermatitis of infectious origin that responded readily to ordinary antiseptic treatment did not appear to belong properly in the same category as this obstinate, rebellious disorder.

DR. PUSEY stated that he had seen more cases of dermatitis repens in the last few months than he had ever seen before. He believed the prognosis was fairly good in the early cases, but in the older cases they never got well. Dermatitis repens, as he understood it, was a suppurative inflammatory process beginning usually on a finger and then spreading with an undermined border.

His idea of dermatitis repens was not just as Dr. Ormsby described it. His conception was a process which was very often an acute process due to pus infection and which would yield to treatment. There was another group of cases, subacute in intensity and practically incurable, such as Dr. Ormsby described, but they were not exclusively entitled to the name dermatitis repens.

CASE FOR DIAGNOSIS. Presented by DR. HARRIS.

The patient was a woman, aged 36, married, who presented an itching rash on the legs, arms and body, which had been present for one year. This rash was a chronic generalized eczema. The interesting feature of the case was a reticular appearance of the skin of the outer surface of the leg. It looked much like a cutis marmorata but the red reticulum alone showed scaliness. This was very different from the eczematous eruption on the rest of the body. The family history was negative, and the Wassermann reaction was negative. She was being treated with Lassar's paste and 5 grains of thyroid gland.

DISCUSSION

DR. MCEWEN thought it was primarily a lichen planus.

DRS. FISCHKIN, MITCHELL, FOERSTER, and ZEISLER considered the eruption not a lichen planus, but a lichenification of the skin.

DR. PUSEY thought it was a lichen simplex chronicus Vidal, and did not consider it strange that a chronic dermatitis would produce such pictures at times. In other words, he believed it was a chronic papular eczema with lichenification.

DR. HARRIS thought that was true except for the lesions on the outside of the leg.

SYPHILIS, ERYTHEMA INDURATUM AND LICHEN PLANUS. Presented by DR. STILLIANS.

The patient was a woman, aged 33, a Bohemian. She was infected with syphilis in 1915, neglected treatment and had a gumma of the palate in 1916. Since then she had had three doses of diarsenol, with mercury rubs and iodid most of the time since. Lesions on the calves consisting of large, brown, indurated patches with central ulcers had been present for about a year. There were also hyperkeratotic, dull red nodules on the flexor surfaces of the wrists which had been present for several years and itched considerably at times. Her Wassermann reaction had been negative for over six months, but she was still on treatment. The hole in the hard palate had been closed by a rubber obturator.

CASE FOR DIAGNOSIS. Presented by DR. PUSEY.

The patient was an old man with an extensive superficial ulcer involving the skin of the cheek over an area 2½ inches wide and 4½ inches long. The lesion was very superficial, showing a bright red surface with borders without

induration or nodules. The history was that it had existed for several years and had gradually spread to its present extent.

The glans penis was atrophic and glistening and showed two or three gray horny areas.

DISCUSSION

DR. PUSEY believed the condition on the face was epithelioma, changed in appearance by radium treatment. There was in addition an atrophic glistening condition of the glans, which represented one of the cases Crocker had described as balanitis perstans. The speaker thought it was essentially identical with kraurosis vulvae.

SEBORRHEIC DERMATITIS. Presented by DR. HARRIS.

The patient was a girl, aged 18, a factory worker. The disorder had been present about two years. The lesions consisted of yellowish, greasy, scaly areas on the scalp; also weeping, sharply defined areas in each axilla and the genital and suprapubic regions. The case was very resistant to treatment and showed a marked tendency to recur. There was present also a bilateral purulent otitis media.

TUBERCULID. Presented by DR. HARRIS.

The patient had been shown at the last meeting as a case of zoniform papulonecrotic tuberculid with a generalized tuberculous lymphadenopathy of Sternberg.

A biopsy showed necrotic tubercles with characteristic epithelioid and giant cells.

CASE FOR DIAGNOSIS. Presented by DR. MCEWEN.

The patient was a man, aged 53, a cabinet maker by occupation. Family history was negative; he denied venereal infection. The disorder had been present for nine months with lesions beginning on the neck which were described as "scratch marks which blistered and made the clothes wet." The lesions had subsequently spread and involved the neck, chest, back, inguinal region, feet and hands, and had proven very refractory to treatment.

DISCUSSION

DR. MCEWEN considered it a feigned eruption.

CASE FOR DIAGNOSIS. Presented by DR. MCEWEN.

The patient was a man, aged 65, who presented some peculiar lesions on the buttocks which had been present for two or three weeks. The lesions were linear in distribution, crust covered and were apparently going to heal with some scar formation. There were two similar lesions on the ankle but none elsewhere on the body.

VACCINIA (?). Presented by DR. MCEWEN.

The patient was a colored man, aged 30, who presented lesions which had appeared three or four weeks after vaccination and which had been present for two weeks. The lesions were vesicles, in many instances crust-covered and were present in moderate numbers on all parts of the body.

DISCUSSION

DR. PUSEY was doubtful about a vaccinia coming on so long after vaccination. He believed it was simply a pus infection.

DR. STILLIANS asked if vaccinia presented such angular lesions as those causing the marks on this patient's forehead. In the cases of vaccinia he had seen the lesions were all round.

EPIDERMOPHYTON OF WEB OF FINGERS. Presented by DR. HARRIS.

The patient was a woman, aged 21, single. There was a history of syphilis. She presented an eczema of the web and adjacent part of fingers which had been present for about two months. The sharply defined red scaly area extended peripherally from the web of the fingers to a slight extent on to the dorsum of the hand, but to a greater extent along the contact surface of the fingers.

MANHATTAN DERMATOLOGICAL SOCIETY

Regular Meeting, Dec. 11, 1917

HOWARD FOX, M.D., *Chairman*

LICHEN PLANUS. Presented by DR. PAROUNAGIAN.

The patient, Mr. J. T., aged 41, was born in the United States. The lesions were confined to the glans penis and corona glandis only and the duration was about four weeks. The lesions were violaceous in color, slightly itchy, with shining tops. There were a number of circinate patches with a moderate amount of infiltration. In the earlier stages of the disease, on account of the presence of a balanitis-like condition, the diagnosis was not quite clear and a Wassermann test was made with negative results.

The patient was presented on account of absence of lesions elsewhere on the body, including the buccal mucosa, and also such slight amount of itching.

LUPUS VULGARIS. Presented by DR. OULMANN.

The patient was a boy, aged 12 years, who developed a swelling of the right lymphatic gland of the neck and showed a few nodular lesions on the cheek. The swelling softened, was incised and discharged pus. The nodular lesions became partly pustular and two or three more groups developed. At the end of about two weeks the scar also developed the same type of lesions. The case was presented as one of lupus vulgaris, following a tuberculous infection of the lymphatic gland. At one place the lesion had been treated with the solid carbon dioxid snow and at another the gland was excised.

DISCUSSION

DR. SATENSTEIN said he thought it was understood that the carbon dioxid snow did not do these cases much good, as one could not reach the depth of the lesion.

CONDYLOMATA. Presented by DR. PAROUNAGIAN.

The patient, H. L., a boy, 15 years of age, stated that some time during the summer a man took him into a hallway and committed sodomy on him. About two weeks ago sores developed about the anal region, for the treatment of which he applied at the Gouverneur Hospital clinic. Examination revealed a faint roseola, marked adenopathy and extensive condylomata about the anal region. His Wassermann reaction was + + + +. The genitals were free from lesions.

LICHEN PLANUS ANNULARIS. Presented by DR. WISE.

The patient was an adult Chinaman, who had been shown on two or three previous occasions. He presented a number of pigmented lesions, which could be seen at a distance, and appeared to be the remains of some preexisting eruption. He also showed several active circinata plaques and festooned patches, some having centralized lesions, chiefly on the thighs and buttocks. A biopsy was performed, the sections revealing a typical picture of lichen planus. The lesions were also situated on the arms, legs and trunk.

DISCUSSION

DR. MACKEE said that clinically and histologically the diagnosis was lichen planus.

DR. WISE said the histologic picture was unquestionably that of lichen planus and there were no evidences of lepra, either clinically or microscopically or any other form of granuloma.

TERTIARY NODULO-PUSTULAR SYPHILODERM, SIMULATING FOLLICULITIS NASI. Presented by DR. GOTTHEIL.

The patient, a man, aged 40, was admitted to the City Hospital, Nov. 30, 1917, for an eruption on the nose, cheeks, and lip. He presented the picture of an inflammatory rosacea, complicated with a folliculitis; there were a few dark red tubercles on his nose, but the predominant features of the eruption were the general swelling and redness of the nose, the adjacent part of the cheeks, and the upper lip, with a large number of apparently peripilous pus infections. The ordinary features of the nodular syphiloderm were entirely lacking. After a short period of observation, however, the diagnosis became evident; the follicular pustules enlarged and became small circular ulcerations, and the nodular character of some of the lesions became evident. He had had a rosacea for years, with occasional inflammatory papules and pustules and thought that his present affection was merely an exacerbation of his old trouble. The combination of a follicular pustular syphiloderm with the syphilitic nodules, and with his old acne and rosacea, was interesting. His history was corroborative. He had syphilis at 20; at 25, fifteen years ago, he had a "paralysis," from the after-effects of which he was still suffering.

Of importance in this connection was the undoubted fact that at the City Hospital they were no longer getting the brilliant immediate results from salvarsan that they formerly obtained. The secondary eruptions and mucosal lesions persisted for weeks, and receded very slowly, and the tertiary lesions were recalcitrant. They had employed the various American and foreign substitutes for many months, and owing to the scarcity of the drug, they had to divide the doses. Their conviction was that they secured just as quick and good temporary results from mercury alone; and in almost every case they were obliged to resort to this latter drug in addition to or in place of the arsenical preparations. Reactions with the new preparations were the rule, and were severe.

DISCUSSION

DR. MOUNT said, in regard to arsenical preparations, that he had never seen eruptions fade as fast as they did under the administration of galyl. They seemed to disappear much more rapidly than even under the old salvarsan, and did so under correspondingly much smaller doses, doses of 0.3 gm. He had seen no bad effects.

DR. SATENSTEIN said he had treated a man, who had received three injections of galyl, given every other day. After the third injection, within ten minutes, he complained of severe headache, so that they had to lay him down on the table. The next day he appeared with a general erythematous eruption. He had been presented at the October meeting. It took a number of days for the eruption to disappear. The patient had a large initial lesion of the chin, which had healed up very rapidly. It began to heal the day after the injection. At the end of the first week it was covered over with epidermis.

GUMMATOUS PERIOSTITIS OF THE FOREHEAD. Presented by DR. PAROUNAGIAN.

The patient was a woman, aged 35, born in Russia, and married. She was seen at the Gouverneur Clinic with a swelling on the forehead about the region of the left frontal eminence, about the size of a hazel nut. The duration

was five weeks; it was a firm, painless and immobile mass. She gave no history of any value, she had had no miscarriages, but had three healthy living children. She stated that she suffered with severe headaches for several weeks prior to the appearance of the swelling. The Wassermann reaction was ++++. No treatment was administered prior to the presentation.

DISCUSSION

The consensus of opinion was that the lesion was a syphilitic periostitis.

ERYTHEMA MULTIFORME. Presented by DR. WISE.

The patient was an adult woman, who had been presented on a number of occasions, and was originally a patient of Dr. Gottheil's, who made the diagnosis of erythema multiforme during one of the patient's attacks. She was presented a month previously with a questionable diagnosis of erythema multiforme because the lesion so closely resembled lupus erythematosus. They were still not positive regarding a diagnosis of erythema multiforme, and considered lupus erythematosus of the discoid type, as she presented lesions of a more or less discoid character, with raised edges and depressed interiors, persisting for weeks with little signs of involution.

GUMMA. Presented by DR. PISKO.

The patient was an adult colored woman, who exhibited an ulcerated gumma of two years' duration, and who had had a number of salvarsan injections. She also had been given salicylate of mercury injections and while the lesion healed for awhile, it always broke open again. It was now most painful, as the lesion was in the knee joint and she could not sleep at night on account of the pain, and she had not had the use of the leg for some time. When she received any form of treatment, either mercury or salvarsan, she immediately became salivated, and felt still worse, and then the sore broke open again. The speaker brought the patient before the Society to ask what he should do for her. She nursed a baby, which was apparently well. She had a ++++ Wassermann reaction, taken repeatedly. The baby's Wassermann reaction, taken twice, was negative. The baby was now 14 months old and she still nursed it.

DISCUSSION

DR. GOTTHEIL said in this connection he would like to call attention to a case that he was unable to bring before the Society, as the man was confined in a wheeled chair. He entered the hospital about six weeks previously for a very deep and extensive ulceration of his right thigh, which had been present some two months. His left leg had been removed at the middle third of the thigh two years ago, in a hospital of this city, but he had not gone back to that hospital for fear they would amputate his remaining limb. The lesion that he persented was a very extensive and very deep gummatous ulceration on the back of the left thigh; it was so large that a clenched fist could be placed in it. He was immediately given appropriate treatment, with the result that his lesion was practically cured. His history was that the lesion on the left thigh was precisely similar to the present one on his right; that an immediate amputation was done, without preliminary treatment. Inquiry at the hospital in question showed no record of either a microscopic examination or a blood examination; the disease was simply called a deep ulceration of the leg. The patient was an old syphilitic. It seemed justifiable to conclude that the lesion for which his leg was amputated was a gumma. In his opinion such lamentable mistakes occurred with unjustifiable frequency. A few days' treatment would have demonstrated the nature of the lesion and saved the man his leg. He could adduce more than one similar instance from private practice.

DR. G. H. FOX said that years ago one used to see twenty or more cases like the one presented, where one was seen now. He said if the woman would wean her child and get out into the fresh air, daily, her general physical

condition would improve. He would advise curettage of the lesion, or what was next best to curettage, the old fashioned mercurial plaster. He had seen such ulcerations heal up in a very short time under this treatment, although gummous lesions in this locality were usually obstinate. He thought the mercurial plaster was the simplest and easiest method of local treatment. A great deal of suppuration tended to produce healthy granulations.

Dr. Gilmour said he had found good results in these cases by filling up the hole with a 10 per cent. blue ointment and putting a bandage for support from the toe to a point above the knee, as in this case, to hold the knee still. In addition one might strap the leg.

Dr. Parounagian said the lesion ought to heal up with salvarsan, and he did not think that the patient should be put to bed.

Dr. Satenstein said they had lost sight of one point, that the patient was very susceptible to mercury, no matter in what form, and she became salivated. He had a similar experience with a patient, a man of about 25 years, an athlete, in good physical condition, with a syphilitic infection. No matter what injection of mercury was given, it would salivate him. Even ¼ grain of salicylate, or 1/30 or 1/40 grain of bichlorid. The speaker then started him on 1/25 grain of calomel, combined with strychnin, to ⅓ and ½ grain a day, and found in about two weeks, that he could then give the patient ½ grain of salicylate of mercury without salivation.

Dr. G. H. Fox said he thought that iodid of potassium would certainly tend to heal these lesions more quickly.

DERMATITIS VENENATA. Presented by Dr. Ochs.

The patient was an adult colored man, who worked in an ammonia plant, and presented an eruption of dermatitis venenata. When the case came to the speaker, the Friday previous, the face was covered with fine vesicles and he noticed it was then of a peculiarly yellowish color, which unfortunately could not be seen when the patient was shown. The back of his neck was covered with yellow lesions, also the upper part of the chest and his nails. The speaker said he had had two or three cases of that kind of skin poisoning. He called attention to the color of the patient's nails, which in the day time were distinctly yellow.

MILIARY PAPULAR SYPHILID. Presented by Dr. Wise for Dr. Rosen.

The patient was a man, aged 33, unmarried, from Dr. Fordyce's clinic. He had had no chancre or any venereal disease. He presented a generalized eruption consisting of pinhead sized papules, some of them arranged in corymbiform groups; in some areas, especially on the back, the individual lesions were difficult to differentiate from a lichen planus eruption. There was no evidence of an initial lesion on the skin or mucous membranes. He had suffered from arthritis during the previous week. The eruption was of four weeks' duration and was accompanied by a moderate generalized adenopathy.

PITYRIASIS ROSEA IN A SYPHILITIC. Presented by Dr. Wise.

The patient was a male adult and presented a well marked pityriasis rosea, located chiefly on the abdomen, thighs and buttocks. On the right side of the back, on the right flank and chest, were a series of depigmented smooth scars, the result of a healed nodulo-serpiginous syphilid, the distribution of which coincided with that of a herpes zoster eruption.

LICHEN PLANUS. Presented by Dr. Pisko.

The patient was a colored male adult. The case was shown because of the lichen planus eruption, consisting of large groups and large papules, which were seen on the face and forehead—a rare localization. The lesions seen

on the forehead were of three years' duration. There were also lesions on the scrotum, legs, trunk and back of the neck. Itching was intense.

DISCUSSION

DR. SATENSTEIN said he would suggest chronic eczema and lichenification with acute eczema of the ears and neck, instead of lichen planus.

DR. WISE said he did not think this man had lichen planus, and would hesitate to call it prurigo on account of the age at which the patient had acquired it. Prurigo began in childhood and left pits and scars. Although the skin of the arms and legs resembled prurigo, he did not think it that condition and would call it a papulo-vesicular eczema, which had assumed a peculiar lichenification.

DR. HEIMANN (by invitation) said it looked like prurigo, but the history was against that. Brocq had in his numerous writings described what he originally called neurodermite, which subsequently changed to pruritus with lichenification. He described a type of the latter disease which occurred in numerous papules accompanied by areas of lichenification. The speaker said that was his point of view, and one might adopt it, if one did not want to use the term prurigo, Hebra. In any case the patient had a chronic, catarrhal, exudative inflammation with lichenification, and the speaker said a Latin name made less difference than the main underlying fact.

DR. G. H. FOX said that in view of the many cases of prurigo he had seen under Hebra and a few cases in America, he would not think of prurigo in this case any more than of varicella, on account of the pustules and umbilicated lesions. The speaker would not say that it was not a lichen planus, but about the ears and back of the neck and on the lip, there were undoubted manifestations of eczema, in a typical chronic form.

CASE FOR DIAGNOSIS. Presented by DR. OCHS.

The patient was a male adult, who was presented with a question of whether the condition was syphilis or tuberculosis. Eighteen years previously he had what he termed a carbuncle at the back of the neck, which was cut, leaving a large scar. From that time until about two years before presentation, he had comparative freedom from his carbuncles, having a few alternately on his wrists and legs, leaving scars. Two years previously a lesion started as a mass between the shoulder blades and ever since he had been getting quite a number of similar lesions. The treatment at that time was free excision and bichlorid dressings. In spite of that, the condition persisted, and on his hands, especially on the left hand, could be noticed small papulo-necrotic tuberculids. Also on the anterior surface of the chest, and on the back, as well as about the umbilicus were grouped lesions that were fungating, and at times putrid. He had a lot of scars on the legs, resembling the scarring of an old syphilis, some of which were stellate and others were small, not rounded, but oblong in character. The anal folds also presented a number of scars. Dr. Wise had also seen this case and suggested a diagnosis of fungating tuberculosis cutis and thought it the first case of its kind to be presented before the Society. A biopsy had been taken, which would be reported on. The Wassermann reaction was +. The patient had received arsenobenzol and the speaker thought the condition had improved since that time.

DISCUSSION

DR. WEISS said he would like to know if blastomycosis could be ruled out.

DR. WISE said he was unable to see any resemblance to either blastomycosis or syphilis in any of the lesions. He considered the entire eruption to be one of fungating tuberculosis of unusual type.

Dr. Heimann (by invitation) said he was afraid that any opinion might be premature and misleading. In order to have a preparation ready that evening a small piece was run through very rapidly, reserving the rest of the material for more careful manipulation. However, so far as the slide went, there was nothing typical of tuberculosis in it, excepting in one respect, and certainly nothing typical of syphilis. There were no vascular changes as one would expect in processes that had been present as long as this. The features noted were as follows: The epidermis was very much thickened and edematous, otherwise there were no changes. The changes that they did find were in the papillary body and corium, and were localized to the lymphatics, both independent of and about blood vessels. In these lymphatics there was a proliferation of what would seem to be endothelial cells, in some places filling the lymphatics completely. The cells were slightly egg-shaped, or almost spherical. Thus there was a stasis, causing an outpouring of lymph among the collagen fibers, giving the picture of early local elephantiasis. There were no giant cells, a few epithelioid cells, no polynuclear cells and an occasional plasma cell. From the absence of large numbers of plasma cells and vessel changes, syphilis could be excluded. Because of the absence of giant cells the typical picture of tuberculosis was absent, and from the absence of polymorphonuclear cells it was easy to exclude blastomycosis and other fungous diseases. Thus the speaker thought they were probably dealing with that form of tuberculosis which Jadassohn described as beginning in the lymphatics and secondarily involving the skin. This form was that called tuberculosis fungosus. The possibility of the eruption being related to the leukemia group was also suggested by the lymphatic involvement. The speaker did not think that any definite conclusion was possible until further investigation was completed, but he was inclined to think that it belonged to the type of tuberculosis described by Jadassohn.

Dr. Gilmour said he would like to know from where the biopsy was taken. He asked if a piece had been taken from a smaller lesion.

Dr. Wise suggested that several biopsies may be needed to demonstrate the tuberculous structural changes.

D. L. Satenstein, M.D., Secretary.

Review of Dermatology and Syphilis

Under the direction of Fred Wise, M.D., New York
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ACTAS DERMO-SIFILOGRAFICAS

(February-March, 1917, 9, No. 3)

Abstracted by V. Pardo, M.D.

THERAPEUTIC ERRORS CAUSED BY MISINTERPRETATION OF THE WASSERMANN REACTION. J. de Azua, p. 109.

It is a well known fact that the Wassermann reaction is not always positive in cases of syphilis, and is frequently negative in cases of active syphilis, but nevertheless many physicians rule out syphilis as soon as they obtain a negative blood test. The author mentions several instances in which a negative Wassermann reaction led to the most terrible consequences; a man with a syphilitic sore of the lip was being treated for a carcinoma, but meanwhile he had infected his whole family (his wife, two sons, one daughter, one grandson and two servants), and this man had a negative Wassermann, which his physician thought a decisive argument against syphilis. Azúa concludes that it is necessary to have the test performed in a qualified laboratory and that a lesion, clinically syphilitic, must be treated specifically despite a negative Wassermann, giving the treatment a fair chance to clear up the diagnosis. It must not be forgotten that lupus, carcinoma, etc., may develop in syphilitic patients who give a positive blood Wassermann.

SYPHILITIC REINFECTIONS AND SUPERINFECTIONS. J. Peyri, p. 119.

Not a long time ago, syphilis was considered to give everlasting immunity, but recently numerous cases of reinfection have been recorded showing that the disease may be acquired a second time. The author of this article believes that a syphilitic patient can be superinfected, that is, can contract a syphilitic sore followed by secondaries while still suffering from an anterior attack of the disease. According to Peyri a patient having had syphilis may present: (1) a recurrent chancre (chancre redux) as a demonstration that his treatment has not been sufficiently strong to destroy all the spirochetes in situ; (2) a chancrelike syphiloma (tertiary manifestation); (3) a superinfection (new attack of the disease while still suffering from one formerly contracted), and (4) a reinfection (a cured syphilitic acquiring the illness anew).

EPITHELIOMA DEVELOPED ON A SYPHILITIC GUMMA OF THE LEG. J. F. de la Portilla, p. 131.

Case report.

LATE HEREDITARY SYPHILIS OF THE NOSE. A. Ledo, p. 137.

Case report.

SECONDARY SYPHILITIC PHLEBITIS. J. Sanz, p. 140.

Case report.

BENIGN CYSTIC EPITHELIOMA. J. Azua, p. 148.

Case report. The lesions, on the face of an elderly woman, developed malignant tendencies after prolonged treatment with radium.

SYPHILITIC MYELITIS OF ERB. J. F. de la Portilla, p. 150.

Case report.

PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE, DERMATOLOGICAL SECTION

(December, 1917. 40, No. 2)

Abstracted by W. H. Guy, M.D.

CIRCINATE ERYTHEMA. E. G. Graham Little, p. 1.

Recurring circinate lesions for five years were thought to be ringworm for some time, but repeated microscopic examinations were negative. The eruption appeared in the summer time and would clear up spontaneously in a few months. A pink papule was the first thing noticed; this spread peripherally and cleared to some extent at the center, the edges being raised. The thighs, abdomen, sacral region and buttocks were the sites of predilection. Moderate itching was complained of. An alternate diagnosis of erytheme annulaire centrifuge (Darier) is offered.

LUPUS ERYTHEMATOSUS OF THE SCALP. E. G. Graham Little, p. 4.

The diagnosis of ringworm of the scalp being established clinically and supported by a positive laboratory report, epilation was accomplished by the roentgen ray and it was found that a typical eruption of lupus erythematosus was present and that it was aggravated and spread rapidly after the radiation. Patchy permanent alopecia resulted which the patient was inclined to credit to the roentgen rays. It is interesting to note that the patient stated that there was considerable redness of the parts before any treatment was applied. Dr. Pernet, in discussing the case, expressed some doubt as to whether the spores were ever present or not.

CONGENITAL ICHTHYOSIS. J. H. Stowers, p. 7.

Ichthyosis sauroderma. A case report.

EXTENSIVE NEVUS. George Pernet, p. 9.

An extensive mildly verrucose nevus involving the corset area of the trunk and upper part of the thighs and buttocks, the fronts of the knees, with a boot and glove-like distribution about the feet and hands, the soles and palms being involved.

DERMATITIS DUE TO HIGH EXPLOSIVES. J. H. SEQUEIRA, p. 12.

Four cases were seen after the recent air raids. First, there was noticed a yellow staining and after about nine days there was an abundant vesicular eruption on the sides of the fingers and on the palms of the hands. The eruption became confluent and ultimately the epidermis peeled. A new explosive, now under investigation, is said to be the cause of this dermatitis, but the case report does not make clear whether direct contact with the explosive is necessary.

ARCHIVES OF PEDIATRICS

(December, 1917, 34, No. 12)

Abstracted by W. H. GUY, M.D.

STROPHULUS. DOUGLASS W. MONTGOMERY, p. 910.

The author describes the eruption as occurring in crops, spaced or overlapping, so that lesions in all stages of development may be present synchronously; nettle-rash wheals, papules, papulo-vesicles, and excoriated papules, scattered principally over the trunk, and to a less extent on the face and limbs. He notes that the condition has also been described under the name of lichen urticatus, of lichen simplex acutus, and of urticaria papulosa. Attention is directed to intestinal disorders as being etiologic, and treatment suggested accordingly.

INFANTILE SYPHILIS OF THE LIVER. EDWARD L. BAUER, p. 927.

A case report of interest, in that an infant born of apparently normal parents developed normally up to the eleventh month, when he suddenly became jaundiced; the abdomen was distended and pendulous; the veins on the anterior abdominal wall were distended; the liver was markedly enlarged with smooth and rounded edges; and considerable fluid was present in the abdomen. The diagnosis was made on finding that the mother's blood showed a positive Wassermann reaction, and necropsy findings in the child verified the clinical diagnosis of syphilis congenita.

AMERICAN JOURNAL OF SYPHILIS

(October, 1917, 1, No. 4)

Abstracted by C. C. TOMLINSON, M.D.

SYPHILIS OF THE PULMONARY ARTERY; SYPHILITIC ANEURYSM OF THE LEFT UPPER DIVISION; DEMONSTRATION OF SPIROCHAETAE PALLIDAE IN WALL OF ARTERY AND ANEURYSMAL SAC. ALDRED SCOTT WARTHIN, p. 693.

This article consists of a study of the macroscopic and microscopic pathology of syphilitic changes in the pulmonary artery with a review of the literature on the subject. A case is reported which had been studied clinically and which was later studied at necropsy and from laboratory specimens.

Changes in the pulmonary artery were found to be identical with those found in syphilitic aortas.

Spirochaetae pallidae were demonstrated in the walls of the pulmonary artery. The author concludes that syphilis of the pulmonary artery and syphilitic aneurysm of the pulmonary artery are definitely demonstrated as pathologic entities.

SOME OBSERVATIONS ON LATENT OR CLINICALLY INACTIVE SYPHILIS IN THE CANAL ZONE. GUY L. QUALLS, p. 712.

A Wassermann test survey of 1,198 colored surgical patients showed 23.7 per cent. syphilitic when there was no suspicion of syphilis and 36.7 per cent. when it was suspected—a grand total of 27 per cent. among all colored employees admitted to the hospital. A total syphilitic infection among the white surgical cases was 15 per cent., with 2.3 per cent. in the unsuspected cases. It is therefore seen that latent syphilitic infection in the colored male employees in the canal zone is exceedingly high.

A COMPARISON OF SOME OF THE IMPORTANT PHENOMENA IN SYPHILIS AND TUBERCULOSIS. FRANCIS M. POTTENGER, p. 718.

Points of contrast in tuberculosis and syphilis are brought out from the standpoints of the infectious agents, pathology, symptomatology, clinical characteristics and treatment.

THE BEHAVIOR OF THE LYMPHATIC SYSTEM IN SYPHILIS. DOUGLASS MONTGOMERY, p. 729.

The author reviews the physiology of the lymphatic circulation and describes the journey of the spirochete from the point of entrance on the surface, to the stage of general invasion. The slow progress of the disease (incubation period) is explained by the fact that the transmission of the spirochetes by way of the lymphatics is necessarily slow. The predilection of the spirochetes for the lymphatics is probably due to the small amount of oxygen found there. Immunity phenomena resulting from early diffuse infection explains the absence of lymphatic involvement in late syphilis.

SYPHILIS OF THE LIVER. H. L. MCNEIL, p. 738.

Syphilis of the liver is divided into three types, namely, acute hepatitis, cirrhosis, and perihepatitis. The author describes the pathologic changes and clinical symptoms in each type.

THE CAUSES OF ARTERIAL HYPERTENSION, WITH SPECIAL REFERENCE TO SYPHILIS—A CLINICAL INQUIRY. JAMES S. MCLESTER, p. 746.

From a group of 124 patients having a systolic pressure of 155 mm. or more, 17.5 per cent. had a positive Wassermann reaction. The author, however, does not agree that syphilis is the chief cause of arterial disease.

SYPHILIS AS A CAUSE OF CHRONIC URTICARIA. H. H. HAZEN, p. 750.

In a series of eighty-nine dispensary cases with chronic urticaria, twenty-eight gave positive Wassermann reactions. All of the twenty-eight patients were relieved of their urticaria by antisyphilitic medication. None of eighteen cases of chronic urticaria seen in private practice had a positive Wassermann, showing the greater frequency of syphilis as a cause of this condition in dispensary patients.

THE ADVISABILITY OF PROSTATECTOMY IN THE PRESENCE OF CORD LESION. E. S. JUDD, p. 752.

Investigation will often show that the patient had urinary difficulty prior to the prostatic age. One should first determine the relative degree of the symptoms of obstruction due to the enlarged prostate, and the extent of the cord lesion.

True incontinence is usually due to a cord lesion, and with the exception of trauma, tabes is the most common cause. If a cystoscopic examination shows the sphincter is functionating and that the symptoms are due to an enlarged prostate, it is proper to operate even though tabes is present. If there is clinical evidence of an advanced cord lesion, or incontinence due to weakness of the external sphincter, operation is contraindicated. The article is concluded with a number of case reports.

THE ROENTGEN DIAGNOSIS OF LUNG SYPHILIS. W. WARNER WATKINS, p. 760.

The roentgenographic shadows of lung syphilis are found to conform to the following types of the disease which are briefly described: (1) syphilitic consolidation; (2) early diffuse sclerosis, and (3) dense sclerosis. The article is supplemented by a number of illustrations and case reports and the author gives the marks of distinction between the roentgenographic findings of lung syphilis and the conditions with which it might be confused.

A PROPOSED STANDARDIZATION OF THE WASSERMANN REACTION. ARTHUR WILLIAM STILLIANS, p. 767.

The author proposes the use of a 50 per cent. glycerinized mixture of strong positive serum to be titrated with each test. It is also suggested that this control serum be supplied from a central depot under government control. Antigens must be standardized by titrating them with positive serums.

WASSERMANN REACTION IN FOUR HUNDRED CASES INVESTIGATED BY GROUP STUDY METHODS. E. V. KNAPP, p. 772.

The purpose of the author's investigation was (1) to determine the relative prevalence of the disease in the male and female; (2) the gross types of the disease present, and (3) the relative value of history, Wassermann reaction, and clinical examinations. A result of the study is tabulated in several charts and summarized by the author as follows: Men are five times more frequently syphilitic than women; the central nervous system shows demonstrable traces of the disease in 50 per cent of the cases; most cerebrospinal cases are males, and the most important single method of examination for syphilis is the physical examination.

A MODIFIED WASSERMANN TECHNIC BASED ON THE RAPID FIXATION OF COMPLEMENT PRESENT IN HUMAN SERUM. C. J. BARTLETT and A. L. O'SHANSKY, p. 776.

A tabulation of comparative findings with the routine Wassermann test and the author's modification in 900 serums, is submitted. The modification consists in the use of the natural complement and antisheep amboceptor found in the patient's serum and no preliminary incubation at 37 C. for complement fixation. The results as given show the modification to be more delicate and more reliable than the routine Wassermann test.

A FEW POINTS OF PUBLIC PROPHYLAXIS AGAINST SYPHILIS. A. RAVOGLI, p. 788.

The paper deals with a study of syphilis from a public health standpoint and a discussion of the methods of handling the various problems met. A most important consideration is hospital treatment of prostitutes with legal control over them, until manifestations have cleared at which time they may leave the hospital but must remain under sanitary surveillance.

THE TECHNIC OF THE COMPLEMENT FIXATION TEST FOR SYPHILIS. CHARLES F. CRAIG, p. 802.

The author gives a detailed description of the methods of preparing the different materials used in the test, also methods of performing the test. He uses guinea-pig complement, antihuman-blood amboceptor, alcoholic extract of fetal syphilitic liver, and human red blood cells.

NEW YORK MEDICAL JOURNAL

(Nov. 24, 1917, 106, No. 21)

Abstracted by C. C. TOMLINSON, M.D.

PROPHYLAXIS IN SYPHILIS OF THE CENTRAL NERVOUS SYSTEM. ISADORE ROSEN, p. 970.

Owing to the fact that involvement of the central nervous system takes place during the early secondary period, the author emphasizes the importance of routine lumbar puncture at this time as a guide for treatment.

A summary of the value of the different laboratory findings and a brief outline of the author's plan of treatment is given.

(Ibidem, Dec. 1, 1917, 106, No. 22)

WASSERMANN COMPLEMENT FIXATION TEST FOR SYPHILIS. J. WHEELER SMITH, p. 1030.

The article deals with a discussion of the literature on the choice of an antigen. The author calls attention to the experience of Smith and MacNeal, who found, using 496 serums, that a simple alcoholic extract with ice-box incubation, gave the most delicate and reliable results.

(Ibidem, Dec. 8, 1917, 106, No. 23)

TREATMENT OF SYPHILIS WITH ARSENOBENZOL POLYCLINIC. CHARLES H. J. BARNETT, p. 1073.

The author presents case reports and tabulations on his work with arsenobenzol, concluding his article as follows: 1. Arsenobenzol is the best and safest substitute for salvarsan and neosalvarsan. 2. It compares favorably with the results obtained in primary and secondary syphilis treated with salvarsan and neosalvarsan. 3. It is nontoxic whereas every one of the other substitutes such as arsenobenzol Billon (French) or the diarsenol (Canadian) are much more toxic and in some cases more so than even salvarsan. 4. It is best given in 0.4 gm. doses, once a week, until the Wassermann reaction becomes negative.

A CASE OF NASAL SARCOMA CURED BY RADIUM. OTTO J. STEIN, p. 1075.

Report of a case.

(Ibidem, Dec. 15, 1917, 106, No. 24)

CONDYLOMA ACUMINATUM IN THE ANAL REGION IN THE MALE. CHARLES E. HYDE, p. 1125.

Report of a case.

(Ibidem, Dec. 22, 1917, 106, No. 25)

SPORADIC PELLAGRA. M. E. ALEXANDER, p. 1174.

Report of a case.

MEDICAL RECORD

(Nov. 24, 1917, 92, No. 21)

Abstracted by C. C. TOMLINSON, M.D.

PELLAGRA: ITS ETIOLOGY, SYMPTOMATOLOGY AND TREATMENT. J. F. YARBROUGH, p. 892.

The author contends that pellagra is an acidosis, the result of a carbohydrate or alcoholic diet in which there is practically no protein. He is of the opinion that many cases are not diagnosed because they do not present typical symptoms and says that, "a red, sleek, or fissured tongue, indigestion, constipation or diarrhea, irritability or melancholia, with insomnia and persistent dreaming are sufficient symptoms to warrant a diagnosis of pellagra." About 25 per cent. of the author's cases did not present a dermatitis. Treatment consisted in elimination of carbohydrates from the diet, increasing the alkalinity of the blood through the use of dilute nitric acid, increasing elimination, and the use of blood or saline solution transfusion when the vitality is seriously impaired.

(Ibidem, Dec. 1, 1917, 92, No. 22)

HENOCH'S PURPURA. M. B. WESSON, p. 943.

Report of a case.

JOURNAL OF LABORATORY AND CLINICAL MEDICINE

(October, 1917, 3, No. 1)

Abstracted by OSCAR L. LEVIN, M.D.

THE WASSERMANN REACTION WITH LARGE AMOUNTS OF PATIENT'S SERUM. A. VAN SAUN, p. 61.

The writer tested seventy-four serums according to the Kromayer modification of the Wassermann reaction and found that the use of large amounts of human serum for the Wassermann test is not so reliable as when the ordinary amounts are employed.

(Ibidem, February, 1918, 3, No. 5)

METHODS OF CONTROL OF THE CLOTHES LOUSE (PEDICULUS HUMANUS VESTIMENTI). WILLIAM MOORE, p. 261.

The four methods which may be adopted for the destruction of lice may be summarized as: (1) the destruction of the lice by the vapor of a volatile organic compound worn by the patient as a sachet; (2) the use of louse powders; (3) impregnation of the underwear with an insecticide, and (4) the destruction by heat or fumigation of both lice and eggs in the garments while the patient is bathing.

The author made careful experiments to determine the efficiency of these methods. Sachets were shown to be unsuccessful. Powders are also unsuccessful since effective powders produce irritation when the patient perspires, while powders which do not burn are of no value. Impregnation of the underwear does not appear promising, but a cheese cloth suit impregnated with a saturated solution of sulphur in creosote could be successfully worn outside the underwear. Chlorpicrin can be used as a fumigant, penetrating the clothing and killing the lice in all parts of the clothing in fifteen minutes and the eggs in thirty minutes. By increasing the heat in the fumigation chamber, the temperature required to kill the eggs could be reduced.

THE ETIOLOGY OF SCARLET FEVER.. R. W. PREYER and J. B. KELLY, p. 269.

The blood of nineteen of twenty-four patients suffering from scarlet fever showed the presence of a diphtheroid organism in pure culture. As the identical organism was obtained from the blood of normal individuals and from those with measles and diphtheria the writers do not claim that this organism is the cause of scarlet fever, but think it worthy of much further investigation.

UROLOGIC AND CUTANEOUS REVIEW

(October, 1917, 21, No. 10)

Abstracted by OSCAR L. LEVIN, M.D.

CANCER OF THE SKIN. A. RAVOGLI, p. 541.

Ravogli reviews the various theories concerning the etiology of cancer and narrates its symptomatology, pathology, prognosis and treatment when affecting the skin. It is his opinion that there is something hidden, perhaps a parasite, which stimulates the increased production of epithelial elements. Certain round bodies resembling protozoa have been isolated by him from cancer growths but he cannot state positively whether these are true protozoa or spores, or on the other hand, accidental or artefact globules. He describes an original method for the treatment of cutaneous cancer for which he claims happy results. The method of procedure consists in the removal of the malignant tissue by curettage, and the subsequent application of a mixture containing two parts of lysol, two parts of formaldehyd and one part of ferric perchlorid. The formaldehyd is supposed to destroy the parasites and disorganize the epithelial infiltrating cells; the lysol is used to affect the hyperplastic tissue surrounding the epithelial cells, and the ferric perchlorid to coagulate the blood and lymph, block the vessels and prevent the penetration and infection of the lymphatic system by cancerous cells.

A CONSIDERATION OF THE PATHOLOGY OF ECZEMA. HENRI GOUGEROT, p. 572.

Eczema is defined as a reaction of defense against epidermo-dermic edema, or inflammatory epidermo-dermatitis, provoked by the presence of a toxin, serving to dilute the toxin to the end that it may be less noxious. The pathology of eczema depends on three clinical facts: (1) an eczematizable field; (2) an irritation produced by an intoxication which may be either endogenous or exogenous, and (3) changes relative to a defensive reaction on the part of the organism.

The therapeutics can never be exclusively local. An effort must be made to determine and remove the predisposing underlying factor present. The local treatment should consist of antiphlogistic measures, inasmuch as eczema is from the beginning an aseptic inflammatory reaction.

SOME POINTS ON MALIGNANT SYPHILIS. CHARLES F. MARSHALL, p. 579.

The writer limits the term malignant syphilis to cases of rapidly developing ulceration occurring within a few months of infection, characterized by rapid destruction of tissue, resistance to antisyphilitic treatment and a tendency to recur. He states that the reason why some cases of syphilis take on the malignant form must be looked for in the constitution of the patient or in the virus. It is possible that persons affected with malignant syphilis are those whose ancestors have been most free from the disease, that is, the

development of the disease on virgin soil. As regards the virus, there are two possibilities; especially virulent form or variety of the spirocheta, or a secondary infection with other organisms. Possibly both factors are concerned and malignant syphilis may be due to the infection of a comparatively virgin soil with a peculiarly virulent form of virus. Treatment should consist of local disinfection of the ulcers and the internal administration of tonics.

(*Ibidem, November, 1917, 21, No. 11*)

ELECTRO-THERMIC METHODS IN THE TREATMENT OF RODENT ULCER, WITH A REPORT OF AN UNUSUALLY ADVANCED CASE SUCCESSFULLY TREATED. WILLIAM L. CLARK, p. 601.

The author favors this method rather than surgery, roentgen ray or radium in the treatment of rodent ulcers.

SYPHILIS OF THE STOMACH. OLNEY A. AMBROSE, p. 633.

Syphilis of the stomach produces a diffuse infiltration in the areolar tissue, causing thickening of the gastric wall; local infiltrations in the mucosa and submucosa, forming miliary gummas which may necrose to form ragged edged ulcers; single or multiple nodules and tumors which may ulcerate, or perigastritis with thickening of the gastric wall and the formation of adhesions.

The clinical manifestations depend on the anatomic changes and are those of chronic gastritis, ulceration with or without obstruction, gastric tumor or gummas with or without obstruction, and perigastritis with involvement of adjacent structures.

The following symptoms, especially with a history of syphilis, are suspicious: severe gastralgia, gradual loss of weight, and loss of appetite in connection with symptoms of achylia. Gastric disturbance with a steady decline of the hydrochloric acid spells either malignancy or syphilis.

Three cases of gastric syphilis are reported in which the symptoms disappeared after antisyphilitic treatment.

(*Ibidem, December, 1917, 21, No. 12*)

SKIN DISEASES AND THEIR TREATMENT UNDER WAR CONDITIONS. HENRY MACCORMAC, p. 688.

Textbook descriptions are misleading when applied to cutaneous diseases as encountered under war conditions in France. Numerous unusual types of skin diseases are seen leading to difficulty and errors in diagnosis. This is especially true of scabies, which constitutes the most frequent cutaneous disease observed. Pediculosis is also very common and because of the itching and the similarity of the lesions produced by the pediculus, to those of the acarus, a differential diagnosis is often difficult. The greatest help in the differentiation of the two diseases is the absence of lesions on the penis in pediculosis. In scabies, interdigital vesicles rather than burrows should be sought for; impetigo of the buttocks is pathognomonic, and every patient with impetigo should be regarded with suspicion. Blankets are apparently the main source of transmission of the disease, while horses and venereal origin account for a small and negligible number.

True impetigo contagiosa is rare. Primary impetigo is found most often on the legs and results from the inoculation of abrasions and excoriations with the *Streptococcus fecalis*. It is ecthymatous in type, runs a prolonged course and is obstinate to treatment. The best method of treatment consists in the application of fomentations for several days, followed by the employment of perchlorid dressings as long as the skin will stand it. Painting the lesions with 3 per cent. silver nitrate in sweet spirits of niter, either alone or in

combination with the above form of treatment, has extraordinary, in some cases almost specific, action. The disease tends to pass through three stages, any or all of which may be present: (1) a dry erythemato-squamous condition; (2) eczematization characterized by the presence of weeping surfaces, usually limited to the scalp, and (3) from contamination with streptococci, a condition of impetiginization.

Seborrhea of the scalp is treated by shaving and the application of calamine liniment in the beginning and the more cautious use of more stimulating remedies in the later phases of the disease. Antiseptics seem to aggravate the disease. Treatment away from the face presents no difficulty.

Other cutaneous diseases are less common and present the usual features as observed in civil practice.

Special hospitals are provided for the treatment of syphilis.

PHYSICOTHERAPY OF THE SKIN. J. A. Riviere, p. 684.

The writer enumerates the various physical agents which have been found successful in the constitutional and local treatment of the dermatoses. He describes the indications for the employment of carbonic acid baths, thermotherapy, thermoluminous applications, static electricity, faradization, electrolysis, electropuncture, ionotherapy, hydro-electric baths, roentgen rays, mechanotherapy, high frequency sparks, and radium therapy.

CONTRIBUTION TO THE STUDY OF GRANULOMA FAVICUM. Carlo Vignolo Lutati, p. 689.

As a result of his histologic examinations to determine the manner of formation of the atrophic scars in favus, the author concludes that there are two different forms of histogenetic processes in the development of the scars. One, the most common, is dependent on a chronic folliculitis and perifolliculitis of sclerotizing type. The other, very rare, depends on a granulomatous formation.

EDINBURGH MEDICAL JOURNAL

(October, 1917, 19, No. 4)

Abstracted by Oscar L. Levin, M.D.

ON THE TREATMENT OF YAWS BY SALVARSAN AND ALLIED REMEDIES. Raoul de Boissiere, p. 226.

One hundred and eighty-two cases of yaws were treated with intramuscular injections of novarsenobenzol Billon, arsenobenzol-Billon and kharsivan (B. & W.). The ages of the patients ranged from five months to sixty-five years. The dose administered depended on the age of the patient. All the infants received 1 grain; children from one to four years, 2 to 3 grains; from four to eight years, 3 to 5 grains; from eight to twelve years, 5 to 6 grains, and from twelve to fifteen years, 6 to 8 grains. All patients from fifteen years and upward received a full dose of 10 grains. Considerable pain followed the injections of arsenobenzol Billon and kharsavin, which was relieved by local applications of hot cyllin foments of 1:400 strength, or carbolic acid 1:50. The lesions disappeared in 180 of the cases following the administration of a single dose. A considerable number, however, showed recurrences, especially among those who received the novarsenobenzol.

It is the opinion of the writer that if a sufficient supply of the drug were available to give each sufferer two or three injections, yaws would soon be eradicated in Fiji.

(Ibidem, December, 1917, 19, No. 6)

NOTES ON THE TREATMENT AND CONTROL OF VENEREAL DISEASES. WILLIAM ROBERTSON, p. 360.

A review of the modern methods for the treatment of syphilis with arsenic and mercury. It is emphasized that the two most important agents for the control of the disease are compulsory notification and the employment of calomel ointment for purposes of prevention.

THERAPEUTIC GAZETTE

(November, 1917, 41, No. 2)

Abstracted by OSCAR L. LEVIN, M.D.

SOME GENERAL CONDITIONS BEARING ON TREATMENT OF SYPHILIS. EDWARD MARTIN, p. 761.

The author reviews the subject of the treatment of syphilis. For mercurial medication he prefers the method by inunction and for injection he considers the soluble preparations safer and more efficient than the insoluble. He advises giving active treatment in courses for life. The general bodily health must be maintained and the following are described as indices of health: (1) psychic, the patient's cheerfulness and capacity for sustained and concentrated effort, either mental or physical; (2) body weight, which should be maintained unless excessive; (3) restful sleep; (4) normal appetite and digestion, and (5) normal output from the kidneys.

EPITOME OF THE PRESENT TREATMENT OF SYPHILIS. ALEXANDER RAMSDALL, p. 764.

A summary of our knowledge of the treatment of syphilis.

SOME CONSIDERATIONS ON THE MODERN TREATMENT OF SYPHILIS. CHARLES W. BONNEY, p. 767.

For the abortion of syphilis it is recommended that the patient receive four or five full doses of arsenical compound (0.6 gm. salvarsan or 0.9 gm. neosalvarsan). This is followed by a period of rest for from one week to ten days and intensive treatment with mercury. Twenty-five minims of cypridol, a French preparation, are injected into the gluteal region daily, until evidence of mercurialism appears. This method of treatment, with periods of rest, is continued until from twenty to forty injections of cypridol are administered. A Wassermann test is made at the end of two weeks. If the test proves positive the courses of treatment are repeated; on the other hand, if it is negative, courses of mild treatment are followed.

In the secondary stage, salvarsan is administered immediately but in smaller doses and with more caution because of the patient's decreased tolerance and the danger from the toxins liberated by the destroyed spirochetes. In late secondary syphilis iodin is given.

THE SMALL VOLUME METHOD OF ADMINISTERING NEOSALVARSAN. S. W. MOOREHEAD, p. 770.

It is claimed from a theoretical standpoint that the advantages of giving concentrated solutions of arsenical preparations are: (1) the lessened quantity of fluid added to the content of the cardiovascular system, and (2) a reduction in the impurities which may be injected. From a practical standpoint the

advantages are: (1) a lessening of the toxic effects of the medication; (2) a reduction in the size of the needle, and (3) greater ease of administration.

The alleged disadvantage of the method, that the rapid injection of a concentrated dose is injurious, is avoided by injecting the solution slowly at the rate of 1 c.c. in twenty seconds, so that the medication is diluted by the blood as it flows through the point of the needle.

VIRGINIA MEDICAL SEMI-MONTHLY

(Dec. 21, 1917, 22, No. 18)

Abstracted by Oscar L. Levin, M.D.

CERTAIN MARKS IN THE DIAGNOSIS OF ACQUIRED SYPHILIS. R. M. le Comte, p. 447.

Stress is laid on the value on the dark field illumination examination for spirochetes in suspected lesions and the Wassermann serum reaction in the diagnosis of syphilis.

CANADIAN PRACTITIONER AND REVIEW

(September, 1917, 43, No. 9)

Abstracted by Oscar L. Levin, M.D.

THE VALUE OF THE WASSERMANN REACTION IN THE DIAGNOSIS AND TREATMENT OF SYPHILIS, WITH SOME REMARKS ON THE TREATMENT OF SYPHILIS. A. Schuyler Clark and R. S. Nelson, p. 345.

Book Review

THE INFLUENCE OF SUNLIGHT IN THE PRODUCTION OF CANCER OF THE SKIN. By C. Norman Paul, M.B., Ch.M., Hon. Assistant Physician for Diseases of the Skin, Sydney Hospital; Hon. Physician for Diseases of the Skin, Renwick Hospital for Infants, Sydney; Hon. Dermatologist, Royal Alexandra Hospital for Children, Sydney; Hon. Dermatologist, Royal North Shore Hospital, Sydney. H. K. Lewis & Co., 136 Gower St., London W. C. L., 1918, 10/6 net.

One is likely to be disappointed in this book because the attractive title is not properly supported by the text. The work consists almost entirely of a very excellent description of the clinical symptoms, histology, prognosis and treatment of cutaneous epithelioma, with a similar but short discussion of xeroderma pigmentosum and preepitheliomatous lesions.

The book consists of 57 pages of text divided as follows: The introduction consists of two pages. In this chapter the author calls attention to the fact that the pigmented races in the tropics rarely have cutaneous epithelioma while the white races of Australia are very prone to such lesions especially on the exposed parts.

The second chapter, 3 pages, gives the usual text-book description of xeroderma pigmentosum. No special point is made regarding the influence of light.

The third chapter deals with rodent ulcer and occupies 12 pages. The author calls the basal-cell epithelioma rodent ulcer and employs the term epithelioma to signify the prickle-cell variety. The only item in the chapter to suggest that rodent ulcer may be caused by light is the fact that the disease shows a predilection for the face. Why it does not occur more often on the hands, the neck, forearms, etc., is not explained.

The fourth chapter, 5 pages, discusses dermatitis solaris chronica. This is the condition commonly called sailor's skin or farmer's skin in this country. The author also includes seborrheic and senile keratoses when occurring on the face. Tropical skin is differentiated, although we fail to find any difference.

Three pages are devoted to cutaneous horns which show a predilection for exposed parts.

"Multiple rodent ulcer" is described separately. It is apparently not seen as often in Australia as in this country. The author considers it to be of nevoid origin although the sun might be an etiological factor. Three pages are given to Brooke's epithelioma adenoides cysticum but no claim is made for an actinic etiological factor although it is pointed out that the disease is usually seen on the face. The last 8 pages are devoted to epithelioma (prickle-cell variety).

There are 43 excellent photographs divided as follows: rodent ulcer, 19; dermatitis solaris chronica, 6; cutaneous horn, 2; multiple rodent ulcer, 8; epithelioma adenoides cysticum, 1; tropical skin, 2; malignant epithelioma, 7.

The book is well printed and well bound. It was written with the object of bridging a gap in dermatological text-books. This it fails to do. It is an excellent résumé of what we already know about these diseases and calls attention to the fact that exposure to sunlight may produce dangerous lesions. It is our opinion, however, that a book possessing the title given to this one should discuss the action of light on the skin rather than giving the well-known text-book details of the diseases themselves. No mention is made of susceptibility or idiosyncrasy, the roentgen ray and radium sequelae are not discussed and while the natural reaction and defense on the part of the skin to light is mentioned, it is not studied or discussed at length.

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